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Report of the Commission of Inquiry into the CONFIDENTIALITY OF HEALTH INFORMATION

Commissioner
The Hon. Mr. Justice Horace Krever

VOLUME III

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Consent to Disclosure

The reader will now know that unauthorized disclosure of health information to third parties by individual and institutional health-care providers has occurred frequently in Ontario in spite of the existence of many ethical canons and legislative pronouncements relating to the confidentiality of health information, and of prohibitions against its disclosure without the consent of the patient. However, with respect to the nature or form of a patient's consent to the disclosure of his or her health information, the existing Ontario legislation is inadequate, and the practices vary widely.

Section 48 of Regulation 729 under The Public Hospitals Act, R.S.O. 1970, chapter 378, reads, in part, as follows:

(1) Subject to subsections 2, 3, 4 and 5,
a board shall not permit any person to
remove, inspect or receive information from
a medical record.

.

(5) A board may permit,

.

(c) a person who presents a written
request signed by,

(i) the patient,

(ii) where the record is of a
former patient, deceased,
his personal representa-
tive; or

(iii) the parent or guardian of
an unmarried patient under
eighteen years of age;

.

to inspect and receive information from a medical record and to be given copies therefrom.

The regulation fails to provide any uniform standard for a valid patient consent. Consequently, and not surprisingly, there is a wide variation in the content of consent forms used by hospitals. Some hospital consent forms contain a minimum amount of information, confining themselves to the name of the patient, the name of the hospital releasing information, date, witness and signature. Others require such additional information as the name of the attending physician, the period(s) of hospitalization, the name of the recipient, a description of information to be released, and the purpose for which the information is requested.

Paragraph 21 of section 26 of Regulation 577/75 (Medicine) made under The Health Disciplines Act, 1974, S.O. 1974, chapter 47, defines "professional misconduct" as:

giving information concerning a patient's condition or any professional services performed for a patient to any person other than the patient without the consent of the patient unless required to do so by law;

This definition recognizes the validity of the practice on the part of physicians of disclosing information about a patient to a third person with the patient's consent. As in the case of Regulation 729 under The Public Hospitals Act, no specified requirements as to the form of the consent exist.

Regulation 576 (as amended by O. Reg. 750/78, section 4(3)) under The Mental Health Act, R.S.O. 1970, chapter 269 as amended by S.O. 1978, chapter 50) contains a provision for a standard consent form but is only applicable to the disclosure of the 'clinical record' maintained by 'psychiatric facilities'. This form contains the name of the facility in possession of the clinical record and of the person to whom the information is to be communicated. It does not, however, specify the nature of the information to be released or an expiry date. The prescribed form is in the following language:

Form 14
The Mental Health Act

CONSENT TO DISCLOSURE, TRANSMITTAL OR
EXAMINATION OF A CLINICAL RECORD

I,
(print full name of person)

of
(address)

hereby consent to the disclosure or trans-
mittal to or the examination by

.....
(print name)

of the clinical record compiled in
.....
(name of psychiatric facility)

in respect of
(name of patient)

See Note 5.

.....

(witness) (signature)

Dated the day of 19...

NOTES:

1. Consent to the disclosure, transmittal or examination of a clinical record may be given by the patient or (where the patient has not attained the age of majority or is not mentally competent) by the nearest relative of the patient.

See subsection 3 or section 26a of the Act.

2. Patient.

Clause b of subsection 1 of section 26a of the Act states that "patient includes former

patient, out-patient and former out-patient".

3. Mentally competent.

Clause fa of section 1 of the Act defines "mentally competent" as "having the ability to understand the subject-matter in respect of which consent is requested and able to appreciate the consequences of giving or withholding consent".

4. Nearest Relative.

Clause ga of section 1 of the Act is as follows:

'nearest relative' means,

- (i) the spouse who is of any age and mentally competent, or
- (ii) if none or if the spouse is not available, any one of the children who has attained the age of majority and is mentally competent, or
- (iii) if none or if none is available, either of the parents who is mentally competent or the guardian, or
- (iv) if none or if neither is available, any one of the brothers or sisters who has attained the age of majority and is mentally competent, or
- (v) if none or if none is available, any other of the next of kin who has next of kin who has attained the age of majority and is mentally competent.

5. Signature.

Where the consent is signed by the nearest relative, the relationship to the patient must be set out below the signature of the nearest relative.

Form 14 must also be used in the case of disclosure of information about patients in psychiatric facilities located in general hospitals.

Ideally, an 'informed consent', as applied to the disclosure of confidential health information, should indicate that the person authorizing the disclosure of the information knows precisely what is being released, why it is being released, the possible consequences of the disclosure, and that he or she knows that he or she may refuse to sign the consent, or may rescind it, if appropriate, after it has been signed. Many problems arise because of the absence of standardized requirements for consent forms. Many consent forms do not reflect a truly informed consent. A blanket consent form authorizing the disclosure of all information about an individual is frequently obtained before any information has been collected. Furthermore, without a right of access to his or her own health information, a patient cannot know what information he or she consents to have disclosed.

An example of a 'blanket consent' is the following language taken from the form of an employee's application for group insurance used by The London Life Insurance Company:

I also authorize any physician, clinic or hospital to release to the Insurance Company any information requested for claim purposes.

Hospital representatives who testified during the hearings expressed concern about this form of authorization. Meiri Burn, the director of medical records at Woodstock General Hospital, put the matter this way:

I am dealing with insurance companies at two levels and I am dealing with them on the claims side, and on the underwriting side and I think on the underwriting side I have got major concerns about. The consent they use is blanket. It covers absolutely everything. You have probably seen them. They just cover everything. They always issue you with a photocopy of it and I am really not all that clear in my mind whether the patients that sign these pieces of paper are actually informed of what they are signing, and that is my concern.

Blanket consent forms are used not only for insurance purposes, but also by many employers who require their employees to authorize the disclosure to them of medical information. In its brief, the Canadian Civil Liberties Association said this about blanket consent forms:

While we recognize that employers will frequently have a legitimate interest in health information relating to their existing or prospective employees, there is no need for such blanket consent authorizations. The consent should be limited to what is necessary to fulfill the company's legitimate needs. Where conclusions rather than raw data would suffice, nothing more should be authorized. In most cases, all that the company needs to know is how fit and able the applicant or employee is to work at the various jobs available. While the medical practitioner who examined the patient, of course, would have the data upon which such conclusions are based, there is rarely a need for further dissemination to other company officials. The conclusions as to the person's fitness and ability will usually be enough.

Some of the consent forms used by boards of education in Ontario require parents to authorize the sharing of health information concerning their children between the department of health and the board without specifying the type of information to be exchanged, the identity of the recipients of the information or the purpose for which the information is required. Further discussion of consent forms used by boards of education, employers and the insurance industry can be found in other sections of this report dealing with those subjects. Such blanket consent forms do not reflect informed consent. Their use should be discontinued in favour of a standardized authorization for disclosure of health information in accordance with the criteria discussed later.

An instructive example of legislation designed to correct some of the deficiencies I have mentioned may be found in the bill pending in the U.S. House of Representatives, H.R. 5935, the Federal Privacy of Medical Information Act. Section 115 of the bill reads as follows:

(a) For purposes of this title, a patient has authorized disclosure to a person of medical information maintained by a medical care facility only if--

- (1) the authorization is (A) in writing (B) dated, and (C) signed by the patient;
- (2) the facility is specifically named or generically described in the authorization as authorized to disclose such information;
- (3) the person to whom the information is to be disclosed is specifically named or generically described in the authorization as a person to whom such information may be disclosed;
- (4) the information to be disclosed is described in the authorization; and
- (5) the disclosure occurs before the date or event (if any), specified in the authorization, upon which the authorization expires.

A State, or political subdivision therein, or a medical care facility may impose additional requirements for authorizations by patients of disclosures.

(b) A patient in writing may revoke or amend an authorization, in whole or in part, at any time, except--

- (1) when disclosure of medical information has been authorized to permit validation of expenditures for medical services or based on medical condition by a government authority, or
- (2) when action has been taken in reliance on the authorization

(c) A medical care facility that discloses medical information about a patient pursuant to this section shall maintain a copy of the authorization as part of the medical information about the patient.

I confess that I have been greatly influenced by the approach to the problem reflected in this U.S. bill. In my opinion it should serve as a model.

The standard Ontario consent form should meet the following criteria. The consent must be in writing, signed by the person who is the subject of the health information, dated, and include an expiry date for the validity of authorization. The signature should be witnessed and only the form bearing the original signature should be regarded as a valid authorization. Every authorization form must specify the name or description of the recipient of the health information and of the health-care provider who is authorized to make the disclosure. There should also be a description of the extent and nature of the information to be released. The information to be disclosed may be specific, or as general as all health information about the subject within a specified time period. This criterion permits the subject to restrict the information to be disclosed, but, at the same time, permits him or her to authorize the disclosure of the entire health record if he or she so desires.

Some of the briefs filed contained submissions to the effect that a valid consent should specify the purpose for which the information was required, and I include this requirement in my recommendation. The brief of the Canadian Civil Liberties Association said this:

In those situations where such necessities of life [job, education, insurance etc.] are concerned, the law might be amended to provide that wherever a consent is required, the purposes and intended uses of it must be set out in the document at issue. Sufficient particularity should be required to enable the person signing to know what information is required, who will have access to it, what interests it is designed to serve, and how it will do so. At the very least, such a measure would help to arouse public opinion in those situations where the declared purposes offend public standards of reasonableness. Especially where such public institutions as school

boards are concerned, there might be some consequent political pressures to change the document. In other situations, such declarations might lead to union or consumer pressures. In any event, this amendment could give rise to the creation of a legal remedy. On the basis of an inexpensive and expeditious procedure, the courts should be empowered to declare null and void those statements of purpose which exceed the needs for the consent and those consents which exceed the stated purposes.

This is a legitimate concern which may be remedied in part by the patient access recommendation found elsewhere in this report. Moreover, if the health-care provider believed that the information requested would be detrimental to the physical or mental health of the subject or of another person, the health-care provider could apply to the Health Commissioner, whose function is described in the discussion of patient access, for an exemption from the obligation to disclose the information.

The consent should be subject to the right of the patient to revoke it at any time. He or she should have the power to control the information of which he or she is the subject, provided that the power to revoke does not to affect the disclosure of information, made before the revocation, in reliance on the authorization. A person disclosing information in accordance with his or her patient's written authorization would be well advised to keep a copy of the authorization in the patient's chart or file.

The Patients' Rights Association has suggested this additional condition: "that the form should indicate clearly the consequences to the patient of a signing or refusing to sign the form." Although, to produce a completely 'informed consent', it might be desirable that the patient be fully aware of all the costs and benefits of giving the consent, it seems to me to be a requirement that would be unreasonable in many circumstances. The health-care provider may wish to discuss the probable consequences of the disclosure with the patient, who may then avail himself or herself of his or her right of access. But the assessment of the implications of giving a consent should be left to the patient.

Recommendation:

90. *That legislation permitting disclosure of health information pursuant to a*

patient's authorization require that the authorization:

- (a) be in writing and contain the original signature of the subject of the health information as well as the original signature of a witness;
- (b) be dated;
- (c) specify the name or description of the recipient of the information;
- (d) specify the name or description of the person or institution intended to release the information;
- (e) include a description of the information to be disclosed;
- (f) specify the purpose for which the information is requested;
- (g) include an expiration date or time limit for the validity of the authorization; and
- (h) specify that the individual may rescind or amend the authorization in writing at any time prior to the expiration date, except where action has been taken in reliance on the authorization.

As indicated earlier, The Mental Health Act prescribes a standard consent form for release of psychiatric records. Form 14 contains the name of the facility in possession of the clinical record, and of the person to whom the information is being communicated. It does not, however, specify the nature of the information to be released or an expiry date. All health-care institutions providing psychiatric care governed by The Mental Health Act are required to use Form 14 when disclosing psychiatric information. The Ontario Health Record Association expressed concern about the use of this form in cases in which patients have been treated in the psychiatric ward of a general hospital:

Another problem has surfaced with regard to the special precautions under The Mental Health Act for the protection of the psychiatric record, which has posed a dilemma for many of our practitioners. When a request for information is received regarding a patient who is or has been in a psychiatric ward of a general hospital, the standard authorization form submitted with a request for information is not acceptable, and according to The Mental Health Act, Form 14 must be used. We see the problem being encountered here as basically ethical in nature. By requesting completion of Form 14, the health record practitioner is releasing the information that the person is or has been a psychiatric patient. To counteract this release, at the present time, some hospitals are incorporating the wording of Form 14 into their general consent and we feel the consequence of such action is uninformed consent.

As the Ontario Health Record Association suggests, a request by a hospital that an applicant for health information complete a Form 14 informs the applicant that the patient has received psychiatric treatment; the legally required use of this form in itself reveals confidential information. The fact that there may exist two separate forms for a patient, one for his or her physical care and the other for his or her psychiatric care creates this dilemma.

The desirability of discouraging the stigma still unfortunately attached to mental illness is discussed elsewhere in this report. In the section on 'Hospitals and Other Institutional Health-Care Providers' a uniform standard for the confidentiality of all types of information maintained in health-care facilities is recommended, with a view to facilitating the removal of a 'double standard' of confidentiality for psychiatric and non-psychiatric records. The adoption of a standard authorization for disclosure by any institution providing health-care services would remove the necessity of a separate form for psychiatric records.

Recommendation:

91. *That a standard form of authorization for disclosure of health information, in accordance with conditions (a) to*

(h) of Recommendation 90, apply to all health information maintained by health-care providers, including psychiatric facilities.

A definition of 'mentally competent' is found in The Mental Health Act and is repeated in the prescribed Form 14 as one of the criteria for determining the validity of a consent. The brief of the Ontario Health Record Association, contains this expression of opinion:

The Developmental Services Act does not address the question of competency as it relates to informed consent and The Public Hospitals Act, while it does refer to consents, does not define what is "informed". It is our opinion that the definition of competency as it relates to the ability to give informed consents in The Mental Health Act should be common to all of these Acts.

Mental Health/Ontario, the Ontario division of the Canadian Mental Health Association, believes that proper procedures to determine competency to consent to the release of records are necessary for both psychiatric and non-psychiatric patients and makes the following submission:

The determination of whether a person is competent to consent to the release of the data should be made by a psychiatrist subject to an appeal to the Mental Health Review Board.

Where an individual is found to be incompetent to consent to the release of the data, a valid consent may only be given by the person's legal guardian or, if no guardian has been appointed, the individual's next of kin.

I agree that the determination of whether a person is mentally competent to authorize the disclosure of his or her information ought to be made by a psychiatrist, but situations arise in which an individual may be incompetent to consent purely as a result of his or her physical condition. A problem also exists when a patient has received both psychiatric and physical care in a general health-care institution. While the definition of competency will govern the consent to release the

'clinical record', under The Mental Health Act, it is not now applicable to the authorization to disclose other medical information which may be kept by the health-care provider. Accordingly, the same definition of competency should be incorporated into all legislation relating to the disclosure of health information.

Recommendation:

92. *That when, in the opinion of the health-care provider, the physical or mental condition of a patient prevents him or her from having the ability to understand the subject matter in respect of which consent is requested and from being able to appreciate the consequences of giving or withholding consent, authorization for the disclosure of the information may be given by the patient's nearest next of kin.*

The question of the ability of a patient to give a valid authorization also arises when the patient is a minor, in which case the right to authorize the disclosure of information ought to be exercised by his or her parent or legal guardian. On this issue controversy has centred around the subject of the minimum age requirement for authorizing disclosure, and the suggestion that the consent of the minor patient be required in addition to that of the parent or guardian. Section 48(5)(c)(iii) of Regulation 729 made under The Public Hospitals Act provides that the patient must be at least 18 years of age in order to authorize a request by a person to inspect or receive information from his or her medical record. However, sections 49(a)(i) and 49a(a)(i) of the same Regulation (as amended by O. Reg. 100/74, section 11), provide that a patient must be at least 16 years of age to consent to a surgical operation, diagnostic test or medical treatment. As I say elsewhere in this report, I believe that the right to consent to one's own medical or surgical treatment in a hospital should carry with it the right to control access to one's medical record. The age of majority (now 18 in Ontario) is that at which, under The Mental Health Act, one can authorize the disclosure of his or her own clinical record.

The U.S. House of Representatives' bill, the Federal Privacy of Medical Information Act, previously referred to, provides that a patient may authorize disclosure of medical information from the age of 14, with the option of either the patient or the parent or legal guardian exercising that right

until the patient reaches 18. It has also been submitted that, for a person between 12 and 16, a consent be obtained from both parent and child. The Report of The Task Force on Case Information Disclosure, released by the Children's Services Division of the Ministry of Community and Social Services in October, 1973, set out this point of view:

In the view of the Task Force, a purely age-based criterion for the ability of the child to consent is convenient but arbitrary, insensitive to the differing capacities of children to understand. Since children are to be involved in important decisions affecting their lives, they should be involved in the process of consent to release of their personal information wherever possible. The approach the Task Force favours instead is to decide the ability of the child to consent on the basis of individual maturity. Thus the agency records officer would always seek consent of the child over 16 to external release or transfer of personal information; the judgement of the direct care giver would be sought as to whether to obtain the consent of a child of any age below 16. The consent of parent(s) or guardian would be sought for all children up to the age of 16.

Although there is much to say in favour of the proposal that children aged 14 and 15 should be entitled to authorize the disclosure of their own medical information, it seems to me to be a stronger argument that parents, who are responsible for the care of their children to the age of 16, ought to be given the right to control their children's health information at least until that age. The governing principle must be that a person's competence to exercise control over his or health information should coincide with that person's competence to authorize the provision of health care services.

Recommendation:

93. *That the parent or legal guardian of a patient under the age of 16 years may authorize the disclosure of his or her health information to a third person.*

Research

The provision of information by hospitals and other health-care providers for medical research constitutes an exception to the rule that medical records may not be disclosed to third parties without the consent of the patients concerned. Legislation such as The Public Hospitals Act, R.S.O. 1970, chapter 378, The Mental Health Act, R.S.O. 1970, chapter 269, as amended by S.O. 1978, chapter 50, section 10, and The Cancer Act, R.S.O. 1970, chapter 55, as amended by S.O. 1972, chapter 34, section 1, permits information that would otherwise be confidential to be released to specified medical researchers without informing the patients or obtaining their consent. There are generally some restrictions on the class of person to whom the information may be released; for example, under section 48(5)(d) of Regulation 729 under The Public Hospitals Act information can only be released to members of the medical staff of a hospital who must, of course, be physicians. See section 43(a) of the Act (as amended by S.O. 1972, chapter 90, section 23). Regulation 729 (as amended by O. Reg. 268/80, section 1) provides, in part, as follows:

48.(5) A board may permit,

.

(d) a member of the medical staff
but only for,

(i) teaching purposes, or

(ii) scientific research that
has been approved by the
medical-staff advisory
committee;

.

(f) the Director of the Research and
Planning Branch or the Department
or his authorized representative
approved by the Commission or an

officer or employee of the
Commission who is designated by
the Chairman,

to inspect and receive information from a
medical record and to be given copies
therefrom.

.

(9) Notwithstanding sections 39, 42, 43,
44 and 48, a hospital, when requested to do
so by the Minister, may provide medical
record information and X-ray films to the
Epidemiology Unit of the National Cancer
Institute of Canada for case-control studies
of bladder cancer, gastric cancer and
cerebral tumours.

Submissions were made by researchers to the effect that the
existing provisions are not sufficient and that any further
restrictions, or even a rigid adherence to the existing regula-
tions, would impede research and eliminate access to information
which is now provided. Several examples were given of situa-
tions in which a literal interpretation of the current law did
or would potentially eliminate important sources of information.
At our hearings Dr. Marvin Tile, head of the division of
orthopaedic surgery at Sunnybrook Medical Centre, discussed the
problems encountered in research in his discipline because of
the recent reluctance of hospitals to release patient informa-
tion:

The Royal Commission on the Confidentiality
of Health Records has started to affect our
ability to do clinical research in teaching
hospitals in Ontario. Now we hope that this
is a passing fancy related only to the press
reports when the Commission was just be-
ginning and what brought this all about.
But what has happened in the past, as you
are I am sure all aware, all medical and
surgical treatment in order to be found ef-
fective or non-effective as the case may be
requires very careful clinical follow-up of
patients. If for instance I propose to do
hip replacement surgery in patients, the
only way one can find out whether that is
effective is by calling those patients back

at five-yearly intervals and doing a very careful scrutiny as how they are doing. The same is true of drug therapy.

For various things, there aren't enough patients in any one person's experience to get an overview, and therefore in a university setting we often will say, we'll take the seven Toronto teaching hospitals and get all the patients that have had a certain procedure. In the past this has been quite simple.

We did it through our orthopedic council. We would make a proposal. The proposal would go to the council, it would be passed and it would then be passed on to the record departments of the teaching hospitals and they have a cross index of disease and treatment. With the permission of the chief in that hospital we could then get the names and the disease process of the patient. We could then contact the patient, they could then decide whether they wish to take part in this or whether they didn't wish to, and that's the way it went up until last year.

When all of this came, the record rooms in all of the hospitals reacted in varying, different ways and we were in the middle of a lot of clinical research. They are really quite confused as to what the position is right now.

For instance, taken to its logical conclusion it becomes a Catch-22. The only way we can do clinical research on the patients with total hip arthroplasty is to find out those that had it. But the only way you can do that is to divulge that a patient actually had it, by name. If you don't have a name, you can't ask them.

Now I don't think any department has gone so far as to refuse names, but I can see that as a logical conclusion unless it is brought to the Commission that this can be a problem and that it may in fact interfere in what I think and our department thinks is an

extremely important university function for upgrading health care in our community. So I think that this has to be brought before the Commission and considered.

Another illustration of the shortcomings in the existing legislative scheme arose out of the presentation made by the Faculty of Health Sciences of McMaster University. We have seen that information may be released for the purposes of research, to members of the medical staff. I have already indicated that it is my interpretation of The Public Hospitals Act that only physicians may be appointed to the medical staff of a hospital. Perhaps without being aware of this limitation, and in any event, in order to circumvent this restriction, two distinguished non-physician scientists at that University, both of whom need access to patient information for their important research had, I was told, been appointed to the medical staff of the university hospital.

A third example involved the cancer registry compiled by The Ontario Cancer Treatment and Research Foundation using data it receives from several sources, including hospitals and the Ontario Health Insurance Plan. During the course of our hearings it was discovered that there was no legislative authority for OHIP to release data to the registry. The flow of information stopped for a brief period of time but has now resumed.

I am very sensitive to the problems faced by members of the research community. Because of the essential nature of the work they do and the benefits that accrue to society by reason of that work, it is my view that their demonstrated need for information should be accommodated as much as possible. There is no suggestion that the information acquired by them, to which I have referred, has been abused or misused in any way. The examples given above are simply illustrations of some of the difficulties faced by researchers as a result of existing legislation and the principle of confidentiality. In the case of one important study requiring identifiable patient information, the provision of which was impossible because of the restrictive language of Regulation 729 under The Public Hospitals Act, the solution resorted to was the amendment of section 48 of the Regulation by the addition of subsection 9 which then made possible the release of the information to the National Cancer Institute of Canada for the study without the consent of the patients. The ad hoc amendment of regulations for the purpose of a particular research project is surely a most awkward and unsatisfactory way of dealing with the problem and avoids the difficult policy decisions that must be made. Given the importance of research, an exception to the rule of

confidentiality is justifiable, but the process by which it is determined that, for a given purpose, persons are to be deprived of the right to control information about themselves should be based on articulated and known principles.

The questions when and under what conditions confidential health information should be released to researchers without the consent of patients should be answered as part of the process of weighing the competing valid interests involved in the inevitable conflict between a patient's right to privacy and researchers' and thus society's, need for information. I am persuaded that, in an enlightened society, most persons would agree that, in exchange for the benefits which flow to all members from medical research, some degree of individual privacy must be relinquished. In weighing the loss of privacy against the benefit to mankind, the manner in which the information is handled must be considered as well as the promise of the research itself. The task at hand is to develop guidelines to regulate the access to information by researchers by reconciling, to the greatest extent possible, the right of the individual to privacy with the legitimate needs of society.

As a general statement it can be said that medical research falls into the following three categories: (1) studies which use only statistical data, such as the number of persons with a disease, (2) studies in which subjects are directly involved, such as experiments to test the efficacy of treatment methods, and (3) studies which use identifiable medical records but do not involve patients directly. Because the subjects are not asked to give consent, it is the last group of studies with which the discussion that follows is concerned. These studies fall within the discipline known as epidemiology which was defined in the following extract from the brief of the Faculty of Health Sciences of McMaster University:

Epidemiology in the classical sense may be defined as the study of the distribution and etiology of disease in human populations. Its purpose is to identify specific agents or factors related to people and their environment which may be the cause of disease, or which may identify people who are at high risk for developing a disease. It thus provides a basis for health programs directed to the prevention and control of disease, which would include specifically heart disease, stroke, and cancer, which are the leading causes of death in the western world. Identification of people at high

risk for disease is important in that measures might be developed to prevent their developing disease, or that medical supervision or screening tests where appropriate might be provided so that illness could be identified at an early stage when successful treatment is more likely.

We, at McMaster, would also include under the umbrella of epidemiology the evaluation of the efficacy and safety of new prophylactic and therapeutic measures, as well as the assessment of the effectiveness and efficiency of innovative ways for delivering health care. The need for this latter research is clear if we accept firstly that new procedures should be introduced only when they have been shown to do more good than harm, and secondly that they then should be made available in the most economical way to all who could benefit from them.

Epidemiological studies often depend on the availability of the medical and vital records of large numbers of people, both for the data they contain as well as for ascertaining and identifying individuals for subsequent interview and study, and it is worth noting that these studies are often carried out many years after the information was recorded.

There can be no dispute that epidemiological research has conferred invaluable benefits on society. Examples of types studies requiring identifiable information were given in the McMaster brief:

(1) In a recent publication of the National Institutes of Health, 20% of all malignant disease was attributed to occupational exposure to known carcinogenic agents. While scientists may dispute the exact proportion of occupationally linked cancers, few will deny that the workplace is an important causal source of disease. Classic examples are the asbestos products industry, coke ovens, nickel refining and uranium mining, where risks of particular cancers

have been documented at between 10 and 1000 times that of the general population.

Research aimed at identifying new occupational risks or at quantifying known risks to allow the setting of exposure standards is crucial to the public good because of the large populations at potential risk. The long latent period between exposure and the subsequent development of a detectable tumor (often 20 years or more) makes it difficult to conduct research in this field. Virtually all of the currently known occupational risks have been identified using a retrospective research design in which an historical group of workers in an industry is tracked forward in time to the present day to identify the mortality experience of the group. Rates of mortality due to each cause are calculated for various occupational groups within the industry or by various levels of cumulative exposure to some suspicious contaminant, and compared to what would be expected in a similar but unexposed group.

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(2) Many serious adverse reactions to drugs are too rare to be detected in the clinical trials that precede the approval of a new drug for general use. They will be detectable only if, and when, it is possible to link specific adverse effects in particular patients to these same patients' prior exposure to specific drugs. Information on adverse effects and drug exposures appears in clinical records. Restricted access to these records will impair our ability to detect these adverse drug reactions and thus hinder the prevention of related morbidity and mortality.

(3) Planners, providers and consumers of health services share a concern that the quality of these health services be maintained at an appropriately high level. For this reason, the three groups are vitally interested in the development and execution

of both studies and ongoing surveillance of the quality of health care. The major current strategy for assessing the quality of care involves the assessment of the way in which health professionals care for individual patients, as revealed in the systematic review of those patients' clinical records. Indeed, such reviews provided essential evidence in the recent studies in Ontario that demonstrated the effectiveness and safety of the primary care nurse-practitioner.

In an article entitled "The Epidemiology of Cancer" Cancer 45 (May 15, 1980), 2475-2485, Sir Richard Doll, Regius Profesor of Medicine, University of Oxford, explained the contribution of epidemiology to cancer research:

First and foremost, epidemiological studies have shown that all cancers that are at all common anywhere vary in incidence from place to place and from time to time.

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The second way that epidemiology has contributed to knowledge of cancer has been by correlating these geographical and temporal differences with the prevalence of factors in the environment that could be suspected of causing the disease.

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The third, and by far the most important, contribution of epidemiology has been to test hypotheses by relating the occurrence of a particular type of cancer to the personal characteristics of individuals--either by comparing the past experience of people with and without cancer or by following up people whose personal characteristics have already been defined. Such evidence is seldom easy to interpret.

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In a few instances, laboratory experiments demonstrated that the agent was a carcinogen

in another animal before the human evidence was obtained; these are designated by the section symbol. In the great majority, carcinogenicity was confirmed by laboratory experiments later.

...In recent years, a great deal of evidence has been obtained on relationships between environmental agents and human cancer that can still be interpreted in different ways. In some instances, the laboratory evidence of carcinogenicity is positive, but the human evidence is not. This may mean that the agent is not, in fact, a risk to man; alternatively, it may mean that the effect is weak and that insufficient data have been collected to detect it. Even an agent like cigarette smoke, which is responsible (either wholly or in part) for 40 percent of all deaths from cancer in men in the U.K., would escape recognition as a carcinogen by the standard epidemiological techniques, until cigarettes had been introduced into a country for many years.

...In other instances, the evidence suggests that exposure to an agent may increase the risk of a particular type of cancer by 50 percent, but the laboratory evidence is negative. If the absolute risk of the disease is small, delay in reaching a decision is unimportant. If, however, we are dealing with cancers of the lung, colon, or breast, a 50% increase in the risk implies a major threat to the individuals concerned, producing an attributable risk of several percent in the course of a lifetime. Reserpine is a case in point.

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Lastly, epidemiology may contribute to knowledge of cancer by helping to understand the mechanism by which the disease is produced.

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First, it has shown that practically all types of cancer vary in incidence from person to person, from community to community, and from time to time. Second, it has shown that this variation is associated with differences in the local environment or in the behaviour or genetic constitution of individuals. The knowledge gained in this way has led, directly or indirectly, to nearly all the steps that have been taken to reduce the incidence of cancer in practice.

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There remain three contributions that epidemiology only can make. Unexciting, perhaps, for research workers, these contributions are important for the society that supports research. First, epidemiological observations continue to provide the crucial check on the validity of the hypotheses about the causation of cancer by showing that the disease diminishes in incidence when the suspected causes are removed. Second, they remain essential for the detection of new hazards. With advance of knowledge about the mechanism of carcinogenesis, it should eventually be possible to predict with confidence from knowledge of chemical and physical structure and the results of laboratory investigation whether a new chemical would be carcinogenic to man, and if so, the conditions under which the effect would appear. We are, however, still largely ignorant of the mechanisms of promotion and carcinogenesis and are a long way from that position.

Third, epidemiological observations help to form social policy by providing quantitative measures of risk. The world can never be entirely free from cancer-producing agents. Some risks must be taken, and we need to know how great they are, so that risk and benefit can be properly balanced. Theoretical considerations as yet seldom enable us to deduce the effect of minute doses by extrapolating from the effect of

large ones, and they seldom permit quantitative extrapolations from observations on laboratory animals to man. Only epidemiological observations can enable us to decide whether we need to jettison such useful materials as saccharin, phenobarbitone, isoniazid, DDT, and steroid contraceptives and to determine what the relative risks are of exposing man to the combustion products of nuclear and fossil fuels.

Leon Gordis and Ellen Gold of the Johns Hopkins School of Hygiene and Public Health, in "Privacy, Confidentiality, and the Use of Medical Records in Research" Science 207 (January 11, 1980) 153-156, an article based on their testimony before a subcommittee of the U.S. House of Representatives, illustrated the importance of epidemiological research with concrete examples of important research projects which used medical records in an identifiable form. The following passage appears at page 153:

The major contributions of epidemiology to the understanding of disease have been based on studies in which medical and other vital records of many people were used, both for their data and for identifying those individuals appropriate for subsequent study. The studies were often conducted many years after the information was recorded. Their importance can be demonstrated by the following examples.

1) Cancer. Studies which demonstrated (i) the relationship of cigarette smoking to lung cancer, coronary heart disease, bladder cancer, and other conditions; (ii) an increased cancer risk associated with occupational exposure to substances such as asbestos and vinyl chloride; (iii) the increased risk of several types of cancer after exposure to radiation; (iv) that the daughters of women who received the hormone diethylstilbestrol (DES) during pregnancy have an increased risk of developing vaginal cancer; and (v) that women taking estrogens for menopausal symptoms have an increased risk of developing endometrial or uterine cancer.

2) Cardiovascular diseases. Studies which demonstrated (i) that high blood lipids, high blood pressure and smoking shorten life expectancy, particularly through coronary heart disease; (ii) that women taking oral contraceptives have an increased risk of developing thromboembolism or stroke; and (iii) that administration of anti-coagulants to patients with myocardial infarctions is associated with lower post-infarction mortality rates.

3) Infectious diseases. Studies which led to the development of vaccines for poliomyelitis, measles, and other infectious diseases, and studies which showed that cases of polio subsequent to polio immunization in 1955 resulted from a vaccine lot contaminated with live virus.

4) Child health. Studies which demonstrated (i) that the administration of high concentrations of oxygen to premature infants results in blindness; (ii) that rubella (German measles) or other viral infection of the mother during pregnancy can produce congenital malformations in the infant; (iii) that radiation exposure of the mother during pregnancy is associated with an increased risk of congenital malformation and childhood cancer in her offspring; (iv) that Rh disease (erythroblastosis fetalis) in newborns can be prevented; and (v) that comprehensive care programs for inner-city children and youth are effective in reducing rates of rheumatic fever.

These are but a handful of the studies which have produced important direct benefits for human health by identifying the factors associated with increased risk of disease, facilitating the development of preventive methods, and evaluating new ways of providing medical care and organizing health care delivery. (Some of these studies are considered in greater detail later.) It would be tragic if the potential benefits to society of such research were lost as a

result of restrictions placed on the information available to researchers.

At pages 154 to 155 they continue:

Diethylstilbestrol and vaginal cancer. A few years ago, investigators in Boston demonstrated through an epidemiologic study that when mothers had been given DES during pregnancy to prevent miscarriage, female offspring from these pregnancies had an increased risk of developing a rare type of vaginal cancer when they reached adolescence. (This finding has important implications, since for many years DES was added to livestock feed in the United States.) Three features are particularly noteworthy: (i) the cancer did not appear in the person taking the medication but only in her female offspring; (ii) the cancer appeared some 15 to 20 years after exposure to DES, so it was necessary to go back many years to determine exposures and to identify the drugs taken in pregnancy; and (iii) the girls and young women who had this cancer were first identified through their medical records--only then could their mothers be contacted and studied further. If such use of medical records had been prohibited, or had been permitted only with the consent of the patient, this study--perhaps the first demonstration in human beings of trans-placental carcinogenesis--would have been extremely difficult or impossible to carry out.

There may be other carcinogens that mothers should avoid during pregnancy because of the hazard to their children. To identify these agents, rigorous epidemiologic investigations in which medical records are used are needed to protect the health of women and their children.

Occupational cancers. Workers in certain industries are often subjected to high concentrations of potentially toxic substances. For example, workers exposed to

vinyl chloride were shown to have an increased risk for liver cancer. This finding, which has now been confirmed, was obtained by reviewing and correlating the medical, work, and death records of large groups of employees in specific industries. Without access to these records it would have been impossible to identify and confirm vinyl chloride as a cause of cancer. Also, had there been a requirement that patient consent be obtained before the records were made available, these studies could not have been carried out because many patients had died by the time the study was done or had moved and could not be traced.

We have only begun to scratch the surface with respect to the toxic and cancer-producing potentials of substances to which workers are exposed during their daily labor. Any restriction that would preclude the identification of harmful substances and the documentation of their effects would be a major setback.

Oral contraceptives (the "pill"). Although the pill has been demonstrated to be a highly effective and convenient form of birth control and has been adopted by many women, many epidemiologic studies have demonstrated that women who take the pill for long periods of time increase their risk for blood clots, strokes, heart attacks, high blood pressure, liver tumors, gall-bladder disease, congenital malformations in their offspring, and other conditions. These important findings were primarily the result of large-scale studies in which hospital and medical records were used--studies which, again, would have been impossible to carry out had patient consent been required. Epidemiologic studies of the effects of drugs like the pill are critical for protecting the health and well-being of the public.

Radiation. One of the questions posed by the accident at Three Mile Island in Pennsylvania has been, How serious is the

potential risk to residents of the area who may have been exposed to radiation from the reactor? We know that high levels of radiation are extremely hazardous to human beings, but what is not known with any certainty is the extent of the hazard posed by low levels of radiation. In order to generate data on the hazards presented by low levels of radiation, it is necessary to collect information on a population that was exposed to low-level radiation. If such a population were identified, we would attempt to trace its members and obtain any relevant physician records, hospital records, or death certificates. For comparison purposes, it would be necessary to identify a similar but unexposed population and obtain similar records for its members to determine the rate of disease in that population. Only in this way could we determine whether the exposed group has more disease than the group that was not exposed. For the conclusions to be valid, complete records must be available for both groups. It would be necessary to know names and addresses, to have access to their medical and vital records with personal identifiers included, and to establish procedures for tracing, recontacting, and following up the members of both populations to determine all episodes of serious illness and death. If access to these records is restricted, Americans will be denied information on the hazards of low-level radiation. It is, therefore, essential that Congress ensure that legitimate medical and epidemiologic researchers have unhindered access to medical records. Such access, naturally, must be conditional on the demonstration by the investigator to his institutional review board (IRB) that he has provided adequately for protection of the privacy of the subjects in his study, as described below.

Although the studies discussed above are wide in scope, a common feature is their dependence on access to identifiable medical information. The need for this access was well expressed in the brief of the Faculty of Health Sciences of

McMaster University with respect to studies of occupational health:

This design is clearly based on two pre-existing sources of information. Firstly, industrial records suitable to define the work force at some point in time and to document their occupational exposures. Secondly, mortality information including the date and cause of death. While the industry can often provide some limited mortality information about its workers (through pension and insurance records) most studies rely on access to official death registration information for complete mortality ascertainment. It is this feature which makes epidemiologic research in Occupational Health dependent on continued access to confidential records.

Records used in epidemiological research include hospital records, records of private physicians, prescriptions, insurance records, employment records and any other source of information, such as death certificates, that contains information about an individual's health or exposure to environmental or occupational hazards. The records used are often not created for research purposes but rather to make some type of decision, either to grant a benefit or to treat the individual, and are usually described as administrative records. Compared to medical records compiled by researchers during the course of a study, the records may be incomplete for the purposes of the research. In many cases it would be difficult to develop records specifically for the purpose of the research since the studies are concerned with past events. The incompleteness of the records is one of the factors which makes the use of identifiable data necessary since often two or more records must be linked to obtain the necessary information. An example of the use of multi-source records can be found in the compilation of the cancer registry by The Ontario Cancer Treatment and Research Foundation. The purpose of the cancer registry is to compile a list of all persons in Ontario diagnosed as having cancer to provide researchers with a data base. The information collected is used for a number of studies such as the determination of the incidence rate of different forms of cancer among various geographic areas.

The information in the cancer registry is derived from records compiled by a number of sources. According to information obtained from The Ontario Cancer Treatment and Research

Foundation, 30 per cent of the information is received from hospital separation forms, 5 per cent from regional treatment centres operated by the Foundation, 52.9 per cent from death certificates and 4.6 per cent from pathology reports. It was estimated that 52 per cent of the cases are identified from multiple sources to ensure that the total is as accurate as possible and to confirm the accuracy of information received. In the absence of identifying data on the information sent to the Foundation, the value of the information on the registry would be questionable.

A second way in which identifiable data is used is to enable researchers to identify potential subjects who are then approached by the researchers and asked if they are willing to participate in the research projects. At our hearings at McMaster University, Professor Michael Gent, chairman of the department of Clinical Epidemiology and Biostatistics, gave the following example of how identifiable data would be screened for a study of heart disease:

For example, if you are into a clinical trial in the chronic care unit, let's say, and suppose...and this is actually a real situation...suppose in fact that what you are trying to do is to identify patients who come into the chronic care unit who have unstable angina. The idea being that once you identify those patients, you then formally seek informed consent and ask them if they will take part in the prospective randomized trial.

Now this is a current...it happens everywhere. What would happen is that those patients are not screened out by a physician, by the cardiologist, because he wouldn't have time. What would happen in practice is all the records of every patient who comes into the chronic care unit would be screened by a nurse practitioner. She would go through a process eliminating out non-specific pain and ruling out infarctions, so that one eventually gets down to a group who through her particular skill she is pretty sure they have angina. She will then get a cardiologist in who will then check her records and confirm them.

At another hearing, Dr. C. R. Howe, senior statistician of The Ontario Cancer Treatment and Research Foundation, explained the procedure used by the National Cancer Institute of Canada:

Essentially this is what is involved. What we are asking for, and this is the practice we have carried out in the past, is in fact for an individual physician who diagnoses a patient as having a cancer being in a position to release to us just two pieces of information. Namely, the identity of the patient and the diagnosis. Nothing else.

Now at that point, and he does this in due consideration of the patient's health, etc., whether he thinks the patient is in a physical condition that he can cope with this kind of thing. But given just those two pieces of information at that point we would then like to contact the patient by letter or by phone in which we explain the nature of the study we are carrying out and ask the patient's permission directly to, whether he is willing to participate in the study. If he refuses at that point, then we immediately would destroy the record of that particular individual and his diagnosis.

In this type of project patients are eventually approached and asked for their consent to participate. However, before consent is sought the researcher has already had access to identifiable data.

The importance of privacy is recognized and understood by well-qualified researchers and this recognition is a fundamental requirement of ethical research. The Declaration of Helsinki (1975 Revision) formulated by the World Medical Association, which sets out guidelines for research involving human subjects, includes the following as one of its basic principles:

6. The right of the research subject to safeguard his or her integrity must always be respected. Every precaution should be taken to respect the privacy of the subject and to minimize the impact of the study on the subject's physical and mental integrity and on the personality of the subject.

Similarly, the Guidelines for Human Research, promulgated by the University of Toronto for its Human Experimentation Committee, state:

The privacy of a person may also be invaded by perusal of identifying or identified information about him or her. The key ethical consideration in such use of identified or identifying information is that the privacy of a person should not be invaded except with that person's consent, and must be protected at all times.

It is recognized in the research community that information will not be forthcoming if respect for confidentiality is ignored. In a presentation to a Workshop on Computerized Record Linkage in Cancer Epidemiology in August, 1979, Lorne Rowebottom, assistant chief statistician, Statistics Canada, made the point this way:

We are convinced that a viable statistical system can only be built on the basis of co-operation with respondents who will provide us with accurate data, because they are convinced it serves useful and important purposes and because they know it will remain confidential to Statistics Canada.

In 1977, D. A. Worton, assistant chief statistician, Marketing Services Field, Statistics Canada, in a paper delivered at the XIII Session of the Committee on Improvement of National Statistics of the Inter-American Statistical Institute, observed that:

The most basic prerequisite for the effective operation of an official statistical agency has always been its ability to protect the confidentiality of information which it acquires about individual respondents.

The consent of the subject in research serves two main functions. It allows the individual to control the dissemination of information about himself or herself and provides him or her with information about the use that will be made of the information. It was pointed out in the evidence given at the hearings by representatives from the National Cancer Institute of Canada, The Ontario Cancer Treatment and Research Foundation, and the Faculty of Health Sciences of McMaster University, as

well as in briefs received from researchers, that consent cannot be obtained in all cases. One of the problems involved is that in many studies, particularly those using dated records, it is difficult, if not impossible, to contact the patients to ask for consent. In the period of time between the making of the record and the research, some subjects will have moved, married, divorced, or died. At our McMaster University hearings, concern was expressed by Professor R. S. Roberts, associate professor, Clinical Epidemiology and Biostatistics, that, if the consent of all subjects were necessary, some potential subjects would have to be excluded with the consequence that the results might be of questionable validity because of bias. His comment was as follows:

Supposing, and it's often the way that you've got a mixed ethnic background in your workers, and supposing that working gangs are organized on an ethnic basis because they tend to speak their own language and the Italians may work somewhere, and the mid-Europeans somewhere else and the Irish somewhere else and the English somewhere else. They tend to not be evenly distributed across the work force, but perhaps all of the underground workers are of one kind and all the surface workers are another. And also, the propensity or likelihood of a man on retirement to move back to the old country is different for English-speaking than say Italians or someone else. That would mean that you had a bias in terms of your ability to detect a death. It would be affected by it and this is because you are much more likely to miss someone who has gone back to Europe to retire and subsequently died. That would then write itself back as a bias in comparing underground workers with surface workers, or high exposure to low exposure, because coupled with that exposure would be the ethnic differences in the distribution of the workers.

So I think it's quite easy to think of ways in which biases could occur, and affect conclusions of the study. But we are very rarely in the position of being able to quantify those biases, because we don't have perfect ascertainment.

At the same hearing, the significance of bias in current research was explained by Dr. D. L. Sackett, professor of Clinical Epidemiology and Biostatistics:

Maybe I could respond with an analogy. The extent to which this is a problem depends on the extent to which risk is changed with exposure, as opposed to non-exposure. If we use an analogy from the therapeutic side, several years ago people with malignant hypertension, very high blood pressure and specific changes in their eyes, all died. Eighty-five percent were dead within a year. Any treatment that lowered blood pressure, whether it was surgical or medical, completely reversed that circumstance and cut that death risk by a factor of five.

We are no longer in those kinds of circumstances with regard to most therapeutic interventions. We are talking about reductions not of five times, but maybe one and half times.

In other words, we are into much less dramatic health benefits, which require on the therapeutic side then the performance of true experiments. Because of the risks of bias. That individuals with different prognoses may wind up being treated or untreated, in the non-experimental situation.

It seems to me that particularly with respect to environmental exposures we may well be reaching many of those same areas now. That the differences in risk are not going to be the very dramatic ones of eight to one, ten to one. Heavy cigarette smokers, thirty-three to one for lung cancer. But in fact we may be down to the one and a half to one. The one point eight to one. Such as exists, for example, with cigarette smoking and coronary heart disease. In those kinds of circumstances, relatively small amounts of bias can in fact dramatically turn those results around, particularly when one is talking about quite rare exposures associated with quite common diseases, and in

circumstances in which the total burden of the disorder, even though the risk changes very little with exposure, the total burden of the disorder may be extremely large. So that we are not talking about insignificant health problems.

The difficulty that arises with respect to obtaining consent for the use of records to identify research subjects is not that of the unavailability of the subjects, but that of obtaining consent prior to the identification of the subjects by the researcher. It would, it was agreed by the researchers appearing at our hearings, be possible to have a subject's physician obtain his or her consent before releasing his or her name to the researcher. It was submitted, however, that such a procedure would be ineffective in practice. Dr. A. B. Miller, director of Epidemiology at the National Cancer Institute of Canada, explained:

...this business of studying existing records where in fact to seek individual consent from a patient might create so many difficulties it would be impossible to carry it out. There is, however, in my submission, I suppose this is what I am arguing against within my brief, a middle ground in which essentially a physician may have treated the patient, may have in fact completed his initial assessment, the patient may have gone home and then he remembered there is a study going on in which this patient could indeed participate. It is not so much the fact that whether or not the patient if presented with it initially would have given consent, because I am sure the patient indeed would have done, or most patients would. It is the fact that the opportunity to present this patient with the opportunity to consent has passed, possibly partly because a physician when he is treating a patient initially does not feel that he would wish to burden the patient with the initial concerns of the study, if it isn't a therapeutic study. So that for a therapeutic study where a treatment is involved, then the process goes through automatically. But for an epidemiologic study, when in a sense one is waiting for the treatment to have been completed and then was going to

ask the patient when they had in fact been a convalescent, when they are in a fit state to, prepared to answer questions. Then you have what in fact to us is a practical difficulty of securing consent. I suppose my plea is that in the past, I am not sure this was legally required, if it was we were in ignorance of this, in many respects people were happy to give us this information. Patients were not unhappy that we had it. I would like to see some mechanism built up whereby we can continue to receive it without having the problem of these barriers which keep being built in.

Dr. Howe and Dr. Miller later entered into this discussion of the problem:

Dr. Miller: Because of, as Aileen and I tried to express earlier, the fact that I think this is not something which is uppermost in his mind at the time he actually is dealing with the patient and that it involves an additional procedure subsequently.

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Dr. Howe: Well he may not do it. That's the basic problem. You know, we recognize that physicians are very busy individuals. Their primary concern, of course, is the patient, and rightly so. So therefore, our interests or the interests of society in general in determining disease etiology are secondary to that physician at that time, inevitably. We have found in practice that this procedure in fact tends to lead to a substantial reduction in the number of cases we get. It can in fact lead to a bias.

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Dr. Miller: Well we are not speaking to anything, what we are speaking to is a study which we conducted when we were in fact not in the position we are now in. The unit

when it was initially established was within the central office of the National Cancer Institute of Canada. I had a University of Toronto affiliation, but I wasn't based in the University of Toronto. We were not therefore able to approach people other than using National Cancer Institute letterhead.

We conducted a study of breast cancer in four regions of Canada, in which one of the regions was Metropolitan Toronto. A colleague at the University of Toronto was directly responsible for the approach to the patients through the physicians, and I'm not sure whether he was required to but he said he elected to use that approach, and in the period in which, we know from the data collected from the Foundation, there must have been at least five hundred cases of breast cancer identified, that is in a period of about eighteen months. He only succeeded in identifying one hundred.

Now in three other areas where this was being conducted, in northern Saskatchewan based around the Saskatoon Cancer Clinic, in Metropolitan Winnipeg, and in the area of the Eastern Townships involving Sherbrooke, we have reason to believe, again by comparison to the numbers in the time period in the data accumulated by the cancer registry, that the proportion of cases that were identified and interviewed approached eight percent.

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The understanding of it was that there had been a committee which had looked at access to records within hospitals which had, for the purpose of epidemiological research, which had defined rather narrowly the sort of information that could be obtained and the use made of it. But in fact it was the sort of data, minimal data that we have asked for which Doctor Howe had indicated to you, and our subsequent use of it and in obtaining permission of the patient before

we went any further was approved by the human experimentation committee.

Opposition to the release of identifiable information without the consent of the patient was not based on any specific example of abuse but rested generally on the principle that the rights of the individual to privacy transcend other considerations. There is also an underlying assumption that statistical data will be sufficient to fulfill the needs of most research. The brief of the Ontario Medical Association contained the following statements:

44. The O.M.A. appreciates the need for data collection for statistical purposes. We are supportive of the investigative work being done by the research community towards the understanding and control of various disease processes and in the field of epidemiology. However, we believe strongly that the information needs in these areas can and must be met through the use of medical records without patient identifiers. Society has more to lose through breach of confidentiality than it has to gain from potential enhancement of research if patient records transmitted and stored for statistical purposes retain patient identifiers.

45. In unusual circumstances where patient identification is necessary for research purposes, records containing patient identification should be released only with the written consent of the patient after a proper explanation has been given.

Recommendation No. 5:

That the informed consent of the patient be required for the inclusion of a patient identifier with data from medical records released for statistical or research purposes.

In its brief, the Consumers' Association of Canada submitted that:

Statistical information be made available to research groups for the purpose of advancing

medical research or medical education in the interest of reducing morbidity or mortality. That the use or publication of such information shall preclude the identification in any manner of the persons whose condition or treatment has been studied.

Neither the evidence at the hearings nor the briefs gave examples of any actual harm which has occurred because of the release to bona fide researchers of information without the consent of the individual. Furthermore no examples of potential harm were given. It is, of course, not an invalid argument, as much of this report makes clear, that some degree of harm occurs whenever any breach of confidentiality or loss of privacy occurs. But I say again that an acceptable balancing of conflicting valid interests is our goal. In this context, the competing interests are the benefit to all members of society by the reduction of morbidity and mortality, on the one hand, and harm to members of society by inroads on confidentiality involved in the same research that may confer the benefit, on the other. The debate is between those who argue for complete confidentiality and those who assert, with respect to medical research, that the benefit to society is so great and the potential harm to the individual so small that the right of the individual to privacy should yield to the greater good. Dr. Miller said:

...if we are going to carry out studies we have to abide by these, but our belief that what we have done in the past and what we propose to do in the future does preserve confidentiality in a way which we believe takes cognizance of the concerns of the public in terms of confidentiality, but also their concern that the areas in which we are involved in conducting research are their concerns also.

Public recognition of the importance and value of research is evident from the financial support the community provides to such research organizations as the Ontario Heart Foundation, the Ontario Society For Crippled Children, the Canadian Cancer Society and other similar bodies. There is other evidence of the public's recognition that the welfare of society sometimes requires the qualification of private rights. That evidence can be found in the legislation mentioned above which permits some researchers to have access to medical information without patient consent. This solution to the problem of balancing interests is seen in the recognition, reflected in legislation,

that the eradication of communicable diseases requires the mandatory reporting of these diseases without the consent of the patients affected.

One of the factors that must be taken into account when assessing potential harm is that research information, unless it is abused, is not used to make decisions about an individual, such as those denying or conferring a benefit. Speaking at the Workshop on Computerized Record Linkage in Cancer Epidemiology already referred to, Mr. Rowebottom commented on the reason why Statistics Canada has access to highly sensitive information. He said:

...we have access to data to which many other people do not because our statistical role does not impact directly for good or ill on any of the individuals who provide us with data.

Despite my strong conviction that confidentiality is fundamental, not only to the provision of proper medical care but also to the preservation of the dignity and integrity of the individual, I am persuaded that research is one respect in which the benefit to society by researchers' access to personal health information outweighs the possible risk to the individual. This, however, resolves only the contest between an absolute and a limited right to confidentiality. The determination must still be made of the circumstances in which the balance favours society. Closely related to the issue of privacy is that of the patient's knowledge of how his or her information is being used and what access there is to the information. As I have already pointed out, a secondary function of consent is to make the individual aware of the dissemination of information about himself or herself. Although obtaining consent is not practicable in all cases, an effort should be made to make the patient and the general public aware of the uses to which medical information is put and the protection given to the information acquired.

Since the 1960's the assessment of the benefits, potential harm, the need for identifiable data and the measures necessary to protect confidentiality in most medical research has been the responsibility of human experimentation committees of institutions, usually universities, in which research is carried on. The Medical Research Council of Canada, which funds most medical research undertaken, requires that all projects for which financial support is sought have the approval of a human experimentation committee. The guidelines governing research

carried on by faculty members of the University of Toronto state:

The policy of the University on the use of human subjects will apply to proposed research if, in the course of investigation, an investigator:

.

c) will be using non-public records (e.g. not the telephone book) which contain identifying information about anyone;...

All research conducted under the auspices of the National Cancer Institute of Canada must be approved by a human experimentation committee. And on the analogy of the use of human experimentation committees in research centres, Lorne Rowebottom announced, in August, 1979, at the Workshop on Computerized Record Linkage in Cancer Epidemiology previously referred to, that he was forming an Advisory Committee at Statistics Canada to give advice with respect to the studies that should be supported and generally to assist in any situation involving a decision as to whether the benefits to society sufficiently outweigh the potential harm to the individual.

Recommendations have been made in other jurisdictions, including the U.S.A. and Great Britain, that researchers have access to information without the consent of subjects. In 1973, the Medical Research Council of the United Kingdom said the following in an article entitled "Responsibility in the Use of Medical Information for Research", British Medical Journal (January 27, 1973), 213:

The Council considers that, subject to certain safeguards, medical information obtained about identified individual patients should continue to be made available without their explicit consent for the purposes of medical research.

In the U.S.A. the use of human experimentation committees, or institutional review boards as they are called there, to screen requests for identifiable data is being proposed in bills now before Congress dealing with the protection of the privacy of medical information. The House of Representatives bill, H.R. 5935, which is the culmination of submissions from hundreds of interested parties, contains the following provisions:

Sec. 124. (a) A medical care facility may disclose information it maintains about a patient, without the authorization described in section 115(a), if the disclosure is for use in a health research project (as defined in section 101(5) which has been determined by an appropriate institutional review board (as defined in section 101(6)(b)) to be--

(1) of sufficient importance so as to outweigh the intrusion into the privacy of the patient that would result from the disclosure...

(b) Any person who obtains medical information pursuant to subsection (a) shall--

(1) remove or destroy, at the earliest opportunity consistent with the purposes of the project, information that would enable patients to be identified, unless an appropriate review board has determined that (A) there is an adequate health or research justification for retention of such identifiers, and (B) there is an adequate plan to protect the identifiers from improper use and disclosure;

(2) not disclose in any public report such medical information that would enable patients to be identified; and

(3) not further use or disclose such medical information in a manner that would enable patients to be identified, except, if not otherwise prohibited by law--

(A) for disclosure to an employee (as defined in section 101(3)) of the person who has a need for the information in performing his duties under the project,

(B) in emergency circumstances affecting the health or safety of any individual or involving imminent danger of aggravated property destruction,

(C) for use in another health research project, under the same conditions (including a determination described in subsection (a) by an appropriate institutional review board) and restrictions on use and disclosure applicable under this subsection to the original project,

(D) for disclosure to a properly identified person for the purpose of an audit related to the project, if information that would enable patients to be identified is removed or destroyed at the earliest opportunity consistent with the purpose of the audit, or

(E) when required by law.

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Senate bill S.503 introduced in the 96th Congress has similar sections which would permit information to be released:

Sec. 552 c.

(4) "(H) To qualified personnel subject to the provisions of paragraph 7, for use in a biomedical, epidemiologic, or health services research project, or a health statistics project, if the research plan is first submitted to, and approved by--

"(i) the director of the service provider responsible for such information or the director's designee; and

"(ii) the institutional review board for--

"(I) the organization sponsoring the project,

"(II) the service provider, or health researcher conducting the project,

"(III) another service provider that maintains medical

information also intended to be used for the project, or

"(IV) in the case of a project for which an institutional review board described in subclauses (I), (II), or (III) is not available to review the project, any institutional review board.

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"(7) Qualified personnel granted access to confidential information for research purposes may not identify, directly or indirectly, any individual patient in any report of such research project, or otherwise disclose such confidential information in any other manner, except:

"(A) for purposes of another research project, as authorized by an institutional review board as provided in paragraph (4)(H),

"(B) in emergency situations affecting the health or safety of any individual or involving imminent danger of aggravated property destruction, or

"(C) for disclosure to a properly identified person the for purpose of an audit related to the project, if the information that would enable patients to be identified is removed or destroyed at the earliest opportunity consistent with the purpose of the audit.

The use of a human experimentation committee to determine when identifiable information may be made available to researchers was the subject of discussion in several briefs. The Faculty of Health Sciences of McMaster University submitted that researchers be given unhampered access to medical information, provided that approval had been given by a human experimentation committee. The Ontario Cancer Treatment and Research Foundation proposes that,

Researchers should be prepared for...guide-
lines to encompass some review process which
would establish the benefit to be expected
from the use of the data, evaluate the
competence and integrity of the researchers,
and ensure that unwarranted use of the
information is not permitted, even to
governmental agencies.

At the present time human experimentation committees are established on an ad hoc basis in institutions conducting research. There are neither legislated guidelines, nor uniform standards. Although most medical research is conducted under the auspices of a university, some research using identifiable information is done outside the university setting. At the hearings at McMaster University, examples of non-university research were given:

DR. MUSTARD: I would think the answer to that question is yes, in the occupational health field. You have the Workmen's Compensation Board, indirectly, and the Ministry of Labour, with all the potential to do that.

DR. SACKETT: Certainly, for example, for the first almost twenty years of its operation, the Framingham epidemiology study was of course not university affiliated at all. One has found in the cardiovascular epidemiologic field that enormous amounts of the initial descriptive epidemiology being carried out by life insurance companies, just on the basis of the review of their own initial physical examinations and the subsequent experiences of those cohorts.

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DR. ANDERSON: You indicate the group health groups and so on. There are a lot of examples.

DR. CHARRON: You could add to that research in drug companies, research in government agencies.

Because the types of records used vary widely and the research is conducted under the auspices of several types of

agencies and sponsors, uniform guidelines are desirable. For research to be effective and to justify the deviation from confidentiality, society must be assured that individual rights are being protected adequately. Apprehension by the public that information is subject to indiscriminate dissemination will lead to a loss of confidence in researchers as well as a deterioration in the quality of information given.

I have already pointed out that it is my interpretation of the existing legislative scheme that information from a public hospital medical record may be released for the purpose of research provided that the person to whom it is given is a member of the medical staff of the hospital, that is to say, a physician. In its ethical guidelines the British Medical Association supports limiting the release of data to physicians on the ground that physicians are subject to discipline for a breach of confidentiality. To the extent that this argument is valid, it could be made in Ontario since the non-physician researchers are not subject to the provisions of The Health Disciplines Act, 1974, S.O. 1974, chapter 47 and thus to disciplinary sanctions for professional misconduct. This argument, however, does not take into account the changes which have occurred in medical research. With the growth of specialization and scientific knowledge, scientists who are not physicians have become qualified to carry out some kinds of health research that physicians, as physicians, cannot perform. As Dr. Sackett explained at our hearings:

This is an example in which a key motive is expediency. It seems to me that what you are referring to and what they are clearly examples of would be circumstances in which the person best qualified to carry out a socially important piece of research would be best qualified by virtue of the fact that he or she is not a physician, but is in fact a health economist, or a medical sociologist, or an anthropologist, or a psychologist, and that the very features that make them the appropriate investigators in fact make them not...

The brief of the Association of Genetic Counsellors of Ontario makes this submission:

Medical genetics is now a well established component of the practice of medicine. Because it is relatively new to medicine and because it is often quite complex, physician

geneticists place considerable reliance on colleagues in many specialties and subspecialties within medicine and on other professional geneticists, who often have Ph.D degrees in medical genetics or a related field. It is not unusual for professional geneticists without medical degrees to be directly involved in the delivery of genetic services, including genetic counselling to patients and families, and to be members of the Active Medical Staff of major hospitals.

The existing legislation also fails to take into account the existence of human experimentation committees which require assurance that the confidentiality of information used by the researchers be safeguarded. At the same hearing, Dean Mustard made this point:

In addition, The Public Hospitals Act may have been written without taking into account the ethics committee role...in relation to university research, and I would think there are very few projects which involve access to the records of patients in this institution in which they would not have been reviewed by a committee concerned with the ethical question, including whether the experimental design justified what was taking place. Then that would be approved by the medical advisory committee and that recommendation would be passed to the board of the institution. So indeed if somebody is functioning in addition to what the Act states in a particular research, it will have been given approval through the machinery which is of the medical staff. Whether that's legal or not is another question. At least certainly considerable protections are built into it.

The distinction between physician and non-physician researchers is unnecessary. The confidentiality of the information acquired as part of the research project is best preserved by ensuring that those who have access to it are aware of the need for confidentiality and undertake to protect it. It is not necessary to limit access arbitrarily to a class of people. Researchers are generally sensitive to the importance of confidentiality. There is an awareness that, if the public perceives that

information given to researchers is released in an identifiable form, there will be a reluctance on the part of the public to provide information, the basic tool of the researcher.

The need to preserve secrecy applies not only to identifiable data but to the release of statistical data. Statistical data may be defined as information which cannot be linked to any given individual, such as the number of admissions for heart disease to a given hospital in one week. Statistical information is often used by administrative agencies for planning purposes. For example, the Health Programmes Branch, Department of National Health and Welfare, regularly received such data as length of stay and diagnosis on computer tape from all provincial health insurance plans. At the present time Statistics Canada receives information from Ontario for five separate projects: a hospital morbidity study, which collects data on all hospital admissions and discharges, a study which collects admission and discharge information for all psychiatric hospitals, a tuberculosis registry, an abortion registry which collects information on a province-wide basis, and a study of all patients on renal dialysis. With the exception of the last study, none of the data is now transmitted in an identifiable form.

Non-identifiable data can also be released in the form of "anonymized" microdata, which are facts about an individual, rather than an aggregate, but with data that could identify him or her removed. While, theoretically, the information cannot be associated with an individual, researchers have agreed that it is, in some instances, possible to identify an individual using statistical data either because the group of individuals with the characteristic in question is small or because data from two or more sources are linked, narrowing down the identification of the subjects. Despite the remote possibility of identification, there are specific sanctions against releasing data of this kind in the Statistics Act, S.C. 1970-71, chapter 15. Section 16(3)(e) of that Act provides that the chief statistician may, by order, authorize the following information to be disclosed:

(e) information relating to any hospital, mental institution, library, educational institution, welfare institution or other similar non-commercial institution except particulars arranged in such a manner that it is possible to relate such particulars to any individual patient, inmate or other person in the care of any such institution;

All ethical researchers follow, and should follow, the same practice. All human experimentation committees should require respect for this principle.

Of equal importance is the physical security of the information collected and maintained by researchers. This includes methods of storage, dissemination and destruction. Concern about the storage of data involves the length of time the data are maintained as well as the medium and method of storage. There is obviously a difference in the security of information stored in an identifiable form for a short period of time and that in registries in which identifiable information is kept for indefinite periods of time. The longer identifiable data are maintained the more opportunity there is for abuse or misuse of the information. With the increasing use of computers which allow the storage of data in relatively small spaces, there appears to be a tendency towards an increase in the length of time data are retained. Because the computer also allows the data to be manipulated in several different ways there is also a tendency to collect and keep more information than is necessary, so that it can be used for projects other than that for which it was collected. Of particular concern is the growth of registries which are intended to be continuing compilations of identifiable information. At the present time there are registries for cancer, congenital anomalies, pacemakers, and some surgical procedures. While not all are province-wide, it is clear that the use of registries will expand in the future. The nature of a registry, as discussed previously with respect to the cancer registry, often makes it necessary to maintain the information in an identifiable form. Although registries provide an efficient and economical method of compiling a data base, they do so at the risk of invasion of the individual's right to privacy. In some cases there may, unlike other types of research, be benefits to the individual. If a new treatment is developed for a disease, or if there is a defect in equipment such as a pacemaker, physicians will be able to contact patients quickly. On the other hand, patients may suffer employment or other discrimination if it is discovered that they suffer from a particular disease. For this reason, the growth and security of registries should be subject to constant scrutiny. For recommendations relating to methods of ensuring the physical integrity of data the reader is referred to the section of this report dealing with computers.

Recommendation:

94. *That a health-care facility be permitted to disclose identifiable health information to a qualified*

researcher for the purposes of a research project without the consent of the subjects involved, provided that approval has been granted by an appropriate human experimentation committee whose members must not be confined to the principal investigator's discipline and must include one or more representatives of the public, and provided also that that human experimentation committee has been satisfied that the principal investigator has met the following criteria:

(a) the identifiable information sought is indispensable for the purpose of the research project;

(b) the importance of the research project, in the opinion of the committee, justifies the breach of the subject's privacy; and

(c) the principal investigator undertakes

(i) that he or she will provide adequate physical security for the information;

(ii) that he or she will remove or destroy information identifying the subjects at the earliest opportunity compatible with the requirements of the research project; and

(iii) that he or she will not further disclose the identifiable health information except to persons who must have access to it for the purpose of the project, or in an emergency situation in which there is a risk to the life or safety of a

*subject or another person, or
when required to do so by
law.*

The Unique Personal Health Identifier

Whether a universal number should be assigned by the Government to all residents of Ontario has been the subject of debate in government and among researchers and the public for more than 10 years. As early as 1968 the Study on Numbering Systems for Personal Identification in the Ontario Government recommended the use of the social insurance number as a unique personal identifier. The Medical Research Council of Canada also recommended the adoption of the social insurance number as a unique identifier in a 1968 report entitled Health Research Uses of Record Linkage in Canada. In 1977 the Ontario Cabinet announced its intention to adopt the social insurance number as a unique identifier. Later, however, it decided that the proposed identifier would be limited to health uses and that no action would be taken until recommendations made in this report and the report of the Commission on Freedom of Information and Personal Privacy had been considered.

For the purposes of this section of the report the term "unique health identifier" means a number, determined by the government, and assigned to every resident of the Province. Every person would be assigned only one number throughout his or her lifetime. The number would be sufficiently controlled to prevent a person from having more than one number, a common problem with numbering systems, and to prevent forgery.

Most of the submissions favouring a unique health identifier came from members of the medical research community. Reflecting the interest of researchers and the importance of research, the National Cancer Institute of Canada adopted the following resolution in 1973 and again in 1977:

The National Cancer Institute of Canada considers that there is need for a unique personal identification number for health records, and recommends that the method of choice is to adopt the social insurance number for this purpose. This presumes that a practical method be found for allocating the social insurance number to everyone.

At our hearings representatives of the Institute withdrew support of the social insurance number as the identifier but the Institute continues to support the introduction of a unique identifier.

The primary benefit of a unique identifier cited by the researchers was that its use would enable files from different sources to be linked more efficiently and accurately. Although the need to link data from several files for research purposes is dealt with in my discussion of research, it is useful to refer to several examples which were given during our hearings with respect to the benefits that a unique health identifier would confer. Dr. Rodney May, then an Assistant Deputy Minister in the Ministry of Labour, said that a unique health identifier would make it easier to correlate an employee's level of exposure to toxic substances to subsequent illnesses by enabling researchers to link employment data with health and vital statistics data. Also with respect to occupational health, Professor Robin Roberts, of the department of Clinical Epidemiology and Biostatistics at McMaster University, said that a unique identifier would assist researchers in obtaining mortality statistics of persons who were exposed to industrial hazards. Dr. Anthony B. Miller, director of the Epidemiology Unit, National Cancer Institute of Canada, gave an example of a study done using the social insurance number as an identifier. The number was taken from employees' files to link occupational data with mortality records, making linkage more efficient and accurate since no duplication occurred. Researchers provided the Unemployment Insurance Commission with the name and social insurance numbers of the subjects. That Commission supplied the researchers with the subjects' addresses, dates of birth and other identifying information which was then used to determine whether or not the subjects had died by matching the records with death certificates.

Representatives from the Ministry of Health discussed the ways in which a unique health identifier could be used. Dr. Barbara J. Blake, director of the Public Health Branch of the Ministry of Health, expressed the view that a unique health identifier would be beneficial for public health and epidemiological purposes. It could be used to enable researchers to trace an individual's level of exposure to a toxic chemical, particularly in the work place. She also suggested that it could be used for immunization follow-up. The issue was taken up in the discussion set out below by the following representatives from the Ministry of Health: John A. Sarjeant, executive director, Information Systems Division, Dr. Roch S. Khazen, chief, Family Planning Unit, Programme Advisory Branch and Tom Campbell, Deputy Minister of Health:

MR. SARJEANT: In thinking about the benefits, I think we should bear in mind that the records that we have are anything but complete medical histories. When we talk about health records, in OHIP for example, we are talking about a record of health services rendered. Admittedly, we have a diagnosis on some claim cards, but that's the extent of the health information, if you will. The condition of the patient, let's say. The health information we have is simply a listing of what services were rendered when.

We have more detail, as you know, in the in-patient information which we derive from HMRI, from whom you have heard over the past few months. The in-patient document is fairly comprehensive in that it gives the diagnosis, the length of stay, the names of doctors, treatment, actually there is a primary and secondary diagnosis, and so on.

For research purposes, I might add in passing, perhaps that rather more detailed medical record obtainable through HMRI called in-patient activities, in-patient conditions, provides a facility for research in those conditions that are more serious. In some way then, one could say, with our present information on in-patient information, we can perhaps do most of the kind of research we would like to do anyway, without the ability to link that information with ambulatory care visits that could be had from the OHIP card.

The kind of things that we have thought were attractive over the years in having this ability to link, would be perhaps to link it with occupational information, occupational health is a matter of increasing concern, and we have pictured the facility of being able to link occupational records or environmental hazards with use of the health care system. Again, the use of OHIP data on ambulatory care would not be a comprehensive statement of outcome that would indicate to

what extent the patient or the citizen had used the health care system.

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DR. KHAZEN: In the question of child abuse, if you remember, you may have read about it, where parents do shop from one hospital to another, and the creation of a central registry whereby this information on the child is located or collected, and urging that when a physician sees a child that is suspected abuse, he could call the registry and say have you had this patient before, is the child on the registry. It's a similar system to what you are explaining, and this is on the negative side whereby the physician will withdraw that information where the parents would not volunteer that this child had had accidents before, or x-rays. This has been done on a small scale, without the computer, on some other registries.

Quebec has started a unique identifier in July of 1977, I believe, whereby they would give every newborn a number. This number would stay with the infant, whereby all the information is collected. Now, I don't know how accessible it is for the physicians or the hospitals, when at every admission they could plug in and get that information. This is not available yet. But I could foresee that it might come, because there are little sections whereby this system is adopted on a small scale, with or without computers.

Another point for the benefit of research, but also the patient will benefit. It has been difficult to find out if the kind of lifestyle that was happening ten years ago has produced a disease or a condition. So the preventive aspect would be helpful if you can realize that such activity or insult might lead to a disease in so many years. It would be beneficial for the individual and for the community in general.

When the Canada Health Survey was adopted, Ontario requested linkage with a unique identifier, because the Health Survey was collecting information on lifestyle... smoking, drinking, exercise and so forth. We felt at that point if we had this information on a certain number of individuals...

MR. COMMISSIONER: That was sampling though.

DR. KHAZEN: Right, Yes. If we have it on certain individuals, if we can tie in this information with what we have on treatment records, we might try to connect some of the samples. Okay, they have heart disease, they have hypertension, and they are admitting that their lifestyle was conducive to such. Thereby, we can really promote the preventive aspects of not doing what would lead to these diseases. This was another linkage system with a unique identifier.

MR. SARJEANT: You could do it without the unique identifier, I suppose.

DR. KHAZEN: Yes.

MR. SARJEANT: In that case, where it identified the samples, the idea was to follow them through and keep track.

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MR. CAMPBELL: ...Well then, as I was just going to say, Mister Chairman, that we are talking about a very interesting kind of development, and this has been discussed in the literature, health literature, about records of individual patients and also the use of that kind of large-scale computer for all sorts of diagnoses and so forth. And it's very hard to predict what is around the corner as far as technology is concerned. We have to be flexible to be prepared to take advantage of these things.

I think the kind of thing we are getting into in terms of very, very complete patient records, again it would seem to me would be something different and some different purpose than we've got in OHIP. The record we now have is strictly related to payment.

If we are talking about another kind of system that would facilitate treatment, you are talking about almost a different way to practise medicine. That would be a subject that would be very interesting, but it would be one that would really involve the whole medical profession and hospitals and everything else.

Although the emphasis has been on linkage for research purposes it is also anticipated that a unique identifier would be used to link files for administrative purposes. For example, if an unconscious person is taken to hospital, physicians may need to obtain records of his or her past treatment at that or another hospital. A unique identifier would ensure that any records obtained did in fact belong to that person. There is also the possibility that, in the future, a centralized health record would be accumulated so that health-care providers needing information about a patient's past history would only have to go to one source for information.

It is possible to link files without using numbers. One can rely on such identifiers as name, birthdate and geographic location. The Medical Information Bureau, now known as MIB, Inc., which, in 1977, had files on more than 10 million persons, uses name, birthdate and birthplace to match files. Studies on record linkage using names have been carried out by Statistics Canada and Atomic Energy of Canada Limited and demonstrate that linkage can be accomplished in that fashion.

The Oxford Record Linkage Study, which began in 1963, is an attempt to compile individual health data on a regional basis for research purposes. It is estimated that in 1973 a total of a half million records were collected. Linkage of records was done manually without the aid of a unique identifier but published reports indicate that the effectiveness of the register is somewhat diminished because of linkage problems. In a paper delivered to the Health Records Administrators Section of the Ontario Hospital Association, Martha E. Smith, of the Biology and Health Physics Division of Atomic Energy of Canada Limited, explained that Statistics Canada's success in creating a

mortality data base by linking names and other identifying data demonstrated that a fast, reliable, cheap and accurate system exists for matching records.

Although, when questioned, researchers agreed that linkage by name was possible, two objections were often raised. The first was that linking names rather than numbers increases costs because more data must be stored to ensure accurate linkage, thus increasing the time it takes the computer to make the match. More important, however, was the statement that the use of a number increases the accuracy of the linkage which, in turn, affords greater protection to the individual.

With every linkage there is a risk that the individual's record will be incorrectly linked with someone else's record or that a new record will be started and not linked with previous data. A name can change with marriage or divorce, or it can be improperly entered into the computer. While it is possible to enter a number incorrectly, a check digit can be included in the number used which would indicate that the number was incorrectly entered, thus minimizing the possibility of error. Dr. David L. Sackett, a professor of Clinical Epidemiology and Biostatistics at McMaster University, also contends that the usefulness of the unique identifier outweighs the psychological fear that it creates because it prevents "...the consequences of an incorrect conclusion."

The direct consequences to the individual with respect to incorrect linkage for research purposes may be insignificant because the researcher is not interested in particular individuals and it is unlikely he or she will, as a result of the linkage, take any action directly affecting the individual. However, the inaccurate linkage of records may lead to incorrect results which could indirectly affect the individual and society in general. This problem was considered in a report entitled Health Research Uses of Record Linkage in Canada, prepared by the Medical Research Council. In the report the point was made that,

Name information, of course, provides a less satisfactory basis for linkage among the health related records than would a universal numbering system. In particular, errors due to inconsistencies and changes, although not too serious in some statistical applications, would tend to accumulate where health histories consisting of many events are reconstructed.

The advantages of accurate linkage are as important in administrative record systems as in research and have a more direct effect on a person since an incorrect linkage may result in the denial of benefits. For example, information about one patient's previous treatment for cancer could be placed in another patient's file and forwarded to an insurance company with the result that the applicant is refused insurance. Another suggestion sometimes made is that, if numbers replaced names on files, the confidentiality of records would be enhanced since, even if unauthorized access to a record system were obtained, the records could not be associated with any individual. Even with a numerical identifier, however, it is unrealistic to expect that names would be removed from the files since they would be needed to link new files with already existing files that do not use the identifying number.

Ironically, one of the chief benefits of a unique identifier--the more economical and faster linkage of records--forms the basis of opposition to the introduction of the unique identifier. The concept of personal registers, such as one in Sweden which contains information about birth, marriage, death and other personal data, is viewed with concern by our society. Newspaper articles discussing the topic often refer to "Big Brother" or to the development of a large centralized data bank containing dossiers on all citizens. Proposals for identification cards are, understandably, reacted to with suspicion and hostility, associated as they are in the minds of many with totalitarian regimes which have used identity cards as a means of controlling society. The controversy is often expressed in terms of the rights of the individual as against the state. Many of the same concerns now being expressed in Canada have been expressed in West Germany, which, in 1977, withdrew its plan to introduce a unique personal identifier, and in the United States which recently rejected a proposal to use the social security number on census forms to facilitate linkage. Some of the reasons for opposing the adoption of a unique identifier reflect a fear that it could be open to abuse by a government, perhaps a hostile government, in the future. It is interesting to note that some governments which have introduced population registers have also made contingency plans for the destruction of the registries in the event of a takeover by a foreign power.

Different weight is given by different persons to the advantage of accuracy of linkage that would be made possible by a unique health identifier. What for some is a benefit that outweighs the dangers is for others simply not a sufficient benefit. For example, Richard R. Walker, counsel for Green Shield Prepaid Services Inc., put the matter this way:

...to look at unique identification numbers you are balanced between that ancient problem that has affected us all, of civil liberties versus the risk of mismatching... if I had to take the risk, I would take the risk of mismatching and not identification.

It is possible that, although objection is taken to the use of a numerical identifier, the real fear that the objectors have is that there will be inadequate or ineffective restrictions on the access to the information that can be collected together by resort to the identifier.

The identifying number itself gives rise to problems in at least two respects. The first is that the number could be comprised of several codes which give such information about an individual as birthdate or nationality. This is the case, for example, with the driver's licence, which includes sex and birth date, and with the social insurance number, which includes a code for geographic region of birth and immigration status. The Swedish unique identifier contains birthdate, geographic region, a unique birth number and a check digit. The second concern is that a number would be dehumanizing, and that names, which are not unique, would no longer be used by bureaucracies. Neither of these concerns directly affects the confidentiality of health records but serious consideration should be given to both of them and preventive measures taken before a unique health identifier is introduced, if, indeed, one is introduced. The use of a coded number which could be used to discriminate against any individual should be avoided. The question of dehumanization is a matter of attitude and behaviour on the part of persons responsible for administering record systems and can occur whether or not numbers are used.

As I have already suggested, an analysis of the submissions both for and against a unique health identifier demonstrates that the real issue is not the number itself but control over the linkage of data. At our hearings at McMaster University, Dr. Fraser Mustard, Dean of the Faculty of Health Sciences, went to the heart of the matter:

I think the more important point is, how is the decision made to allow that linkage to occur [between information gathered for a variety of purposes] from the standpoint of myself as an individual who may be involved in a linkage and in the broad public interest. I think if one can devise systems

which maintain individual accountability but allow the aggregate to come forward, and have systems like advisory boards or some such thing to keep control of what takes place, then the identifying number doesn't become as difficult an issue as when somebody uses that identifier to compile a set of information about me which is then going to be used for purposes other than those which are the broad public interest.

A similar point was made on another occasion by Dr. Geoffrey R. Howe, representing the National Cancer Institute of Canada. He said,

I think in that context the important decision to make is, are we justified on whatever grounds in linking two files of information together? If the decision is yes, then I think it's important to get the work done as efficiently as possible...

On the same issue, Dr. Gary D. Anderson, associate professor of Clinical Epidemiology and Biostatistics at McMaster University, had this to say:

...the important thing is setting up a proper accountability structure that guarantees access to those who have the right to access and that are in the public good, and on the other hand provides a mechanism whereby improper access can be controlled and identified... Because there is going to be linkage. People are collecting information, insurance companies, health, across the population. It's going to be possible to link this information and it's going to happen.

There are two possible methods of controlling record linkage. One can restrict the use of the number and one can restrict the linkage of files. The second method requires a body to be created to authorize the linkage of any two files, whether for administrative or research purposes. The body must be accountable to the public and function under guidelines known to the public. This is the approach that is followed in Sweden. There, the Data Inspection Board was created by the Data Act in 1973 to regulate the collection and dissemination of personal data stored on computers. The Board has wide-ranging

responsibilities which include the determination of who sets up a data bank, how it is maintained and to whom information may be disseminated. All computerized data banks, except those created by the Cabinet, must be registered with the Board which is an independent body under the authority of the Swedish government, controlled by a board of directors made up of representatives from political parties and interest groups. Similar data protection agencies have been established or recommended in France, West Germany, Holland and the United Kingdom as a prerequisite to implementing a unique identifier system.

Professor Tore Dalenius, in "Data Protection Legislation in Sweden: A Statistician's Perspective" in The Journal of the Royal Statistical Society, conveniently summarized the relevant provisions of the Swedish Data Act at pages 287-288:

2.2.3. The Swedish Data Act

The SDA was enacted by Parliament in 1973 (Riksdagen, 1973). It is by design an omnibus law, the interpretation and enforcement of which is the charge of the Data Inspection Board (DIB). In what follows, I will present some excerpts of special interest in the present context (for the full text see Vinge, 1974); for the significance of the square brackets, see the Introduction.

(a) Section 1

For the purpose of this Act, the following definitions apply. Personal Information ["data"] means information concerning an individual. Personal Register ["system of records" or "file"] means any register or any other notes made by automatic data processing and containing personal information that can be assigned to the individual concerned.

Note: As defined here, questionnaires (schedules) used in a census or survey and records processed for statistical purposes are special instances of a "personal register".

(b) Section 2

A personal register may not be started or kept without permission by ["a licence from"] the Data Inspection Board.

(c) Section 3

The Data Inspection Board shall grant permission ["licence"] to start and keep a personal register, if there is no reason to assume that...undue encroachment on the privacy of individuals will arise.

(d) Section 5

When granting a permission ["licence"] to start and keep a personal register the Data Inspection Board shall issue regulations as to the purpose of the register and the personal information that may be included.

(e) Section 6

...the Data Inspection Board shall...issue regulations concerning

1. the obtaining of information to the personal register ["methods for data collection for a personal file"]

.

5. information to the person affected ["concerned"].

(f) Section 8

If there is reason to suspect that personal information in a

personal register is incorrect, the responsible keeper of the register shall, without delay, take the necessary steps to ascertain the correctness of the information and, if needed, to correct it or exclude it from the register.

(g) Section 10

At the request of an individual registered the responsible keeper of the register shall as soon as possible inform him of the personal information concerning him in the register.

(h) Section 15

The Data Inspection Board supervises that ADP ["automatic data processing"] does not cause undue encroachment on privacy.

As set forth by the SDA, the main functions of the DIB are:

- (i) issuance of permissions to start and keep personal registers; and
- (ii) supervision of computerized activities in the realm of personal registers; the DIB may act on its own initiative or on the basis of complaints from the public.

In addition, the DIB is to perform these same functions with respect to the Credit Information Act and the Collection of Debts Act.

Mention should finally be made of Section 25, which describes the process of appeal--by the Chancellor of Justice on his own initiative, and by the public--of decisions made by the DIB.

The current debate over the introduction of a unique identifier highlights the need for adequate control over the proliferation and linkage of data banks. Whether one number or a multitude of numbers are used will make no significant difference if limitations are placed on access to data. At the present time, restrictions on access to data files are found in separate pieces of legislation, such as Regulation 729 under The Public Hospitals Act, R.S.O. 1970, chapter 378, each of which refers to records of one kind only. Part of the difficulty of this approach is that many data files are created which are not the subject of any legislation. If all data files and potential linkage could be anticipated, this method of solving the problem might be sufficient if it were not for two inherent problems. The first is the impossibility of foreseeing all the contingencies involved and the second is the likelihood of inconsistencies and conflicts where a multiplicity of statutes is involved.

There is today no designated agency in the government responsible for keeping track of the development of data banks. Until recently the responsibility for overseeing the development of, and access to, data files created by the Ministry of Health was divided among several branches with little communication among them. However, one of the purposes of the unique health identifier is to facilitate the creation of new data files. This is one of the reasons why, as I have suggested, relying on separate legislation for the protection of every data file separately is cumbersome and would be unsatisfactory. To obviate this objection a mechanism must be developed which is flexible enough to deal with all data banks, both those in existence and those to be created, in a way that creates public confidence that data which are collected will not be abused. With respect to the unique health identifier a central agency would have two functions. The first is to ensure that the use of the number is limited to health information and the second is to regulate the linkage of files using a unique health identifier. In order to carry out its first task a determination of what is health information must be made. Although it is perhaps the most difficult task, because, inevitably, it must exclude data files which may be useful or relevant to health concerns, but which are not truly health information, it is also the most fundamental decision to make. The decision to limit the use of a unique identifier to health information is in part a reflection of general concern that the widespread use of the number would lead to a lack of control over the flow of data. Unless the public is aware of the limitations which will be put on the use of the number this concern will not be dissipated.

Once the definition of health information has been arrived at, the central agency must decide whether a data bank falls within the definition before the unique health identifier may be used. If it does, the agency would issue a permit allowing the data collector to require that the source of the desired information also provide his or her identifying number. As experience with the social insurance number clearly demonstrates, it is impossible to restrict the use of the number entirely. The means of detecting and halting the unauthorized use of any number would be too complex to be practicable. However, by requiring that data banks wanting to obtain their subjects' unique health identifiers receive a permit, it is possible, through legislation, to distinguish between authorized and unauthorized users. Any legislation that may be enacted to implement the unique identifier should provide that persons may refuse to provide the number, without any penalty, unless the group requesting the information has a valid permit.

The primary and crucial function of a central agency would be to approve data linkage. In many respects this function resembles the role of the human experimentation committees described in the section of this report dealing with research, except that the procedures would apply to any group or individual, including government, requesting linkage of data. A written request would have to be submitted which would include the following information: data wanted, purpose of the linkage, retention schedule and security precautions. If necessary, further information could be requested.

Guidelines should be formulated with respect to the criteria to be used by the agency to decide when linkage should be permitted, taking into account the purpose for which the information will be used and the length of time it will be retained in an identifiable form. Again, it is important that the public be assured that the linkage of data, particularly in the case of administrative files, will be controlled. As each linkage creates a new data file, permits would be required for every linkage approved by the agency. Only if an Act of the Legislature otherwise expressly provides, there should be no exception to the requirement of approval. To gain public confidence the agency should function openly. All of its decisions should be published, as should the criteria used by it in the decision-making process. The composition of the agency should include representatives from the health sector and the general public. It is desirable that the agency be made accountable to the Legislature directly and that the Legislature's approval of all guidelines and criteria used by it be required in the legislation establishing the unique identifying number.

Another function of the agency would be that of restricting the use of the number to health purposes. This is the approach recommended in several submissions and the method used in other jurisdictions to control the development of large, centralized data banks. None of the submissions proposed any concrete mechanisms for controlling the use of the number but some suggested that it be limited to health use. Dr. Joseph Hauser, formerly the Director of the Health Division of Statistics Canada, expressed the view that there should not be a unique identifier for all records since the risks involved outweighed the benefits, but that Statistics Canada approved of a unique identifier for health information because, for such a limited use, the benefits outweigh the risks. He stopped short of advocating the adoption of a unique health identifier since, he felt, that was a matter for public debate. He added that, in that debate, the public had to consider how far it could trust the government not to make unauthorized use of the number and the government must clearly indicate the uses to which it would put the information collected.

The Canadian Organization for the Advancement of Computers in Health, better known as COACH, did not take a formal position on the unique identifier. Denis Protti, its president, thought that most members of the organization would discourage the use of the identifier because of the fear that the data would be linked with non-health data. He did, however, predict that his organization would, in the future, endorse the use of a health identifier. The Ontario Health Record Association also recommended that a unique health identifier be limited to health purposes, as did Dr. Barry A. Martin, appearing on behalf of the Metropolitan Toronto Forensic Service.

None of the proposals limiting the use of the number for health purposes defined health. The submissions made by the Faculty of Health Sciences at McMaster University assumed that the number would be used on employment records and vital statistics records as well as on such files as hospital records. Many administrative records, for example, those for welfare, unemployment insurance and family benefits, contain health information. One of the difficulties in defining health information is that it will inevitably exclude record systems that may be useful to persons doing health research, such as employment files. That, however, is, in my view, one of the compromises that must be made if it should be decided to adopt the use of the number.

Another difficulty in limiting the use of an identifier for health purposes is that of enforcing the restriction. It is

common knowledge that both the OHIP number and the social insurance number are used by a variety of persons and organizations who have no authority conferred by law to use the number. In passing, it may be mentioned that Inger Hansen, the Privacy Commissioner in the Canadian Human Rights Commission, is currently engaged in a nationwide study of the use of the social insurance number at the request of the Minister of Justice. In the United States, restrictions on the use of the social security number are found in the Privacy Act which requires that anyone asking for a person's social security number inform him or her whether or not it is mandatory that the number be given. If the person is obliged to provide the number, he or she must be given the name of the Act authorizing its use.

Regulating data linkage by restricting the use of the number was opposed by the Privacy Protection Study Commission in the United States. In its report, it said that:

The Commission finds that restrictions on the collection and the use of the [social security number] to inhibit exchange beyond those already contained in law would be costly and cumbersome in the short run, ineffectual in the long run, and would also distract public attention from the need to formulate general policies on record exchanges.

The Commission reasoned that linkage could occur without the use of a number and the cost of forbidding organizations already using the social security number to discontinue using it was too high in relation to the benefit. Applied to a unique health identifier, however, this argument loses its force since any number used would be developed expressly for that purpose. The Privacy Protection Study Commission urged that the emphasis be on the actual linkage, not the use of the number, and went on to recommend:

That the Federal government not consider taking any action that would foster the development of a standard, universal label for individuals, or a central population register, until such time as significant steps have been taken to implement safeguards and policies regarding permissible uses and disclosures of records about individuals in the spirit of those recommended by the Commission and these

safeguards and policies have been demonstrated to be effective.

In the same vein, Dr. Anthony B. Miller, of the National Cancer Institute of Canada, with respect to the political fear of the unique identifier, said at our hearings,

...I recognize that this is a legitimate fear, but I personally feel it is somewhat misplaced, because in practice I think that the security doesn't lie in denying names or denying the application of numbers. It lies in the way society introduces the appropriate checks to the way this can be used, and supervises that these checks are correctly carried out.

While I entirely agree that requiring every mandatory use of a unique identifier to be legislated is cumbersome and is no substitute for the formulation of a clearly defined policy on record exchange, it at least provides a mechanism to control the unnecessary proliferation of the use of the number and acts as a reassurance to the public that its use is being controlled. As we have seen, even with limitations on the use of the social insurance number and promises by the government that its use would be restricted, it has, in practice, become a de facto unique identifier. The danger in the uncontrolled use of a unique identifier is not only unauthorized record linkage, but also unauthorized access to data files. For example, according to the evidence at our hearings, credit bureaus have, in the past, telephoned OHIP and, upon reciting the subjects' OHIP numbers, have obtained biographical data about them. Because a unique health identifier would be a key to highly sensitive and confidential information, it must be protected to the greatest extent possible against abuse. Individuals should not be required to provide the number to any person or organization unless it has been determined that the purpose for which it is to be used is in connection with health information, as defined, and is authorized. The determination of when the provision of the number is mandatory must be made by a body accountable to the public.

Recommendation:

95. (1) *That, if a unique health identifier is adopted by the government, its adoption be implemented only in conjunction with the establishment of a central data*

protection agency responsible for authorizing the use of the unique health identifier and for approving data linkage between files, one or more of which use the unique health identifier.

(2) That the agency be responsible to the Legislature. All proceedings of the agency should be open to the public.

(3) That in deciding whether a data bank should be authorized to use the unique identifier the following questions be considered:

(a) whether the data bank falls within the definition of health information promulgated by the agency; and

(b) whether adequate plans have been made to ensure the physical security and confidentiality of the data.

Both the definition of health information and the minimum security guidelines should be published.

The use of the social insurance number as the unique health identifier would be clearly inconsistent with any plan which limited the unique identifier to health use. Only a completely new number could be controlled in the way in which it should be if it is to be introduced. The social insurance number is now required by several government departments and agencies and is also widely used by banks, schools and employers. As I have already pointed out, the National Cancer Institute of Canada has withdrawn its support of the social insurance number as the unique identifier for health records. Several other submissions were made supporting a unique health identifier but opposing the use of the social insurance number for that purpose. Apart from all other objections the social insurance number is unsuitable because it has been so inadequately controlled that some persons have more than one number.

Recommendation:

96. That if a unique personal health identifier is adopted, it should not be the social insurance number.

Mandatory Reporting of Health Information

Our interest in the subject of mandatory reporting of health information arose out of allegations in a story in the *Globe and Mail*, on November 1, 1977, to the effect that a computer operator at the Ministry of Health had run the computer tape containing the names of persons reported as having venereal disease, for fun. Our investigation of these allegations is dealt with in the discussion in this report of computer-supported systems in health. In the beginning our attention focused on the physical security of data collected by the Venereal Disease Control Section of the Ministry of Health, particularly the data on computer. It was soon realized that, while physical security was essential, it was equally important to address the question whether the reporting of the information, in this case the names of persons diagnosed as having gonorrhoea or syphilis, was necessary at all, and if so, how much information must be collected. These questions arise not only with respect to venereal disease reporting, but must be considered in relation to all mandatory reporting requirements, such as those under The Child Welfare Act, 1978, S.O. 1978, chapter 85, The Highway Traffic Act, R.S.O. 1970, chapter 202 and The Public Health Act, R.S.O. 1970, chapter 377. A list of relevant mandatory reporting requirements is set out as an appendix to this chapter.

By mandatory reporting in the context of this discussion, I mean a statutory requirement which has the effect of compelling a physician or other health-care provider to report health information about a person under his or her care to a designated authority. Here, for example, is the language of section 49 of The Child Welfare Act, 1978:

(1) Every person who has information of the abandonment, desertion or need for protection of a child or the infliction of abuse upon a child shall forthwith report the suspected abuse to a society.

(2) Notwithstanding the provisions of any other Act, every person who has reasonable grounds to suspect in the course of the

person's professional or official duties that a child has suffered or is suffering from abuse that may have been caused or permitted by a person who has or has had charge of the child shall forthwith report the suspected abuse to a society.

In effect, mandatory reporting requirements exempt health-care professionals from a duty of confidentiality, in certain circumstances, by requiring him or her to report information which would otherwise be confidential.

This exemption is brought about by the imposition of a duty in the legislation requiring reporting. For example, section 143(1) of The Highway Traffic Act provides that:

Every legally qualified medical practitioner shall report to the Registrar the name, address and clinical condition of every person sixteen years of age or over attending upon the medical practitioner for medical services, who in the opinion of such medical practitioner is suffering from a condition that may make it dangerous for such person to operate a motor vehicle. [emphasis added]

The exemption is also recognized in and permitted by the legislation governing the health-care provider by excepting legally required reports from the restrictions governing the disclosure of information by a health-care professional. For example, section 26 of Regulation 577/75 under The Health Disciplines Act, 1974, S.O. 1974, chapter 47, provides as follows with respect to physicians:

26. For the purpose of Part III of the Act, "professional misconduct" means,

.

21. giving information concerning a patient's condition or any professional services performed for a patient to any person other than the patient without the consent of the patient unless required to do so by law; [emphasis added]

There are similar exceptions under the regulations relating to most of the other professions governed by The Health Disciplines Act, 1974.

Mandatory reporting contradicts the underlying principle of the health-care relationship that an individual has a right to the confidentiality of health information about himself or herself, including the right to decide to whom the information may be released.

One justification for the interference with the physician-patient relationship is that the benefit which society derives from having information which assists in the prevention or control of disease and bodily harm outweighs the possible harm to the individual in the form of an invasion of privacy. Another justification given is that because society assumes an economic burden in caring for sick members of society it has a right to require those members to do everything reasonable to keep the cost as low as possible. While the right of confidentiality is not absolute, it should not be abrogated without good cause, particularly when an individual, in order to receive necessary treatment, must disclose sensitive information to a health-care provider.

The purpose of this chapter is to explore criteria on which to base the decision to require mandatory reporting and to formulate guidelines for the protection of information once it has been collected. It is not within my terms of reference, as I interpret them, or, indeed, within my competence, to decide whether information, the collection of which is now deemed essential, should be collected, but one must be concerned that no information be collected unnecessarily since every disclosure of information by a health-care provider to a third party increases the possibility that an abuse or misuse of the information will occur.

Mandatory reporting is standard epidemiological procedure in most western nations. Dr. Barbara Blake, Director of the Public Health Branch of the Ministry of Health, testified at our hearings that:

This has been a long, time-tested method of trying to control outbreaks of communicable diseases....

It is therefore not surprising that the other nine provinces have legislation similar to that of Ontario requiring venereal diseases, other communicable diseases and child abuse to be reported.

In the very thoughtful brief submitted by the County of York Law Association there is a helpful discussion of mandatory reporting in Ontario. The brief divides mandatory reporting legislation into two categories. The first category consists of statutes such as The Highway Traffic Act and The Venereal Diseases Prevention Act, R.S.O. 1970, chapter 479, which require that the health-care provider initiate a report when he or she becomes aware of a disease or condition. The second category consists of legislation requiring the furnishing of information to an authority on request, or permitting the inspection of information by the authority, usually for an investigation. For example, section 14(2)(b) of The Coroners Act, 1972, chapter 98, as amended by S.O. 1974, chapter 103, section 6, provides that:

A coroner may, where he believes on reasonable and probable grounds that to do so is necessary for the purposes of the investigation,

.

inspect and extract information from any record or writings relating to the deceased or his circumstances and reproduce such copies therefrom as the coroner believes necessary;

For the purposes of this chapter I shall be concerned only with provisions falling into the first category.

Within the category or provisions which require the health-care provider to make a disclosure even where it has not been requested there are two further divisions: (1) legislation relating to communicable diseases, including venereal diseases, and (2) provisions relating to conditions or diseases which, though not communicable may, nevertheless, affect the health and safety of the subject or other persons.

The requirement that communicable diseases, other than venereal diseases, be reported is found in section 64(1) of The Public Health Act, which is in this language:

Whenever any legally qualified medical practitioner knows, or has reason to suspect, that any person whom he is called upon to visit is infected with any communicable disease, he shall within twelve hours give notice thereof to the medical

officer of health of the municipality in which the diseased person is.

Section 1(a) of that Act (as amended by S.O. 1975, chapter 61, section 1) provides that:

"communicable disease" means smallpox, diphtheria, typhoid fever, rabies, tuberculosis and any other disease designated by the regulations as a communicable disease;

A second list of communicable diseases is found in Regulation 426/78 (as amended by Regulation 855/78, section 1) under The Public Health Act. The lists are not identical.

Venereal diseases must be reported under The Venereal Diseases Prevention Act. Section 3(1) (as amended by S.O. 1971, chapter 33, section 2) reads as follows:

It is the duty of,

- (a) every physician,
- (b) every superintendent or head of a hospital, sanatorium or laboratory; and
- (c) every person in medical charge of any correctional institution, lock-up, training school, school or college or other similar institution,

to report within twenty-four hours every case of venereal disease coming under his diagnosis, treatment, care or charge for the first time to the medical officer of health in the locality in which such diagnosis, treatment, care or charge is made.

Venereal diseases are commonly defined as sexually-transmitted diseases, but for the purposes of the Act they fall within the definition set out in section 1(g) (as amended by S.O. 1971, chapter 33, s.1):

"venereal disease" means syphilis, gonorrhoea, chancroid, granuloma inguinale or lymphogranuloma venereum.

The second division includes legislation such as The Highway Traffic Act which requires physicians and, under section 144(1), optometrists, to report every person attending them who suffers from a condition that may make it dangerous for him or her to operate a motor vehicle, and The Child Welfare Act, 1978, which requires suspected cases of child abuse to be reported by professional persons, such as physicians and others, to a children's aid society.

Another example of mandatory reporting is found under section 9(1) of The Coroners Act, 1972:

Every person who has reason to believe that
a deceased person died,

- (a) as a result of,
 - (i) violence,
 - (ii) misadventure,
 - (iii) negligence,
 - (iv) misconduct, or
 - (v) malpractice;
- (b) by unfair means;
- (c) during pregnancy or following pregnancy in circumstances that might reasonably be attributable thereto;
- (d) suddenly and unexpectedly;
- (e) from disease or sickness for which he was not treated by a legally qualified medical practitioner;
- (f) from any cause other than disease; or
- (g) under such circumstances as may require investigation,

shall immediately notify a coroner or a police officer of the facts and circumstances relating to the death, and where a police officer is notified he shall in turn immediately notify the coroner of such facts and circumstances.

For the purpose of this chapter the distinction between the divisions is not important. In both situations health-care providers are required to breach the confidentiality of a patient. The decision as to whether the required disclosure is necessary, taking into account the benefits and risks to the individual and society, can only be determined by a consideration of each requirement, not a group or category. For example, medical officers of health who receive a report of a highly contagious and lethal disease may need to know the names of persons in contact with the infected person, while the Ministry of Transportation and Communications is concerned with information about an individual relevant only to his or her driving ability.

This chapter is divided into two sections. The first deals with the policy issues which must be considered by those persons responsible for deciding whether to require the reporting of a disease or condition and thus force a health-care provider to breach his or her patient's confidentiality. The second section deals with guidelines for the physical security of the information, and considers the question who should have access to the information once the decision is made that it is to be reported.

We chose to focus our attention on the venereal disease system, as an example of mandatory reporting. This does not imply that the problems are necessarily different from, or more severe than, those of any other system. With the exception of conclusions and recommendations which refer to specific aspects of the venereal disease system, the recommendations which follow may be applied to all current mandatory reporting systems as well as to those which may be created in the future. I shall begin the discussion with a brief description of the procedures followed for the reporting of information about venereal diseases and the kind of information collected.

A patient who suspects he or she has a venereal disease may attend either at a physician's office or at a special treatment clinic for diagnosis and treatment. According to the evidence given by Dr. Ralph Persad, the Senior Medical Consultant in the Venereal Disease Control Section of the Ministry of Health, approximately 80 per cent of the cases of venereal disease reported are treated by private physicians. The special treatment

clinics are funded on a global basis by the Ministry of Health and, accordingly, do not bill through the Ontario Health Insurance Plan for each patient. A list of names of persons who have been seen at each clinic is sent to the Venereal Disease Section of the Ministry of Health daily, containing only the patients' names and birthdates. Unless a clinic specifically requires identification for its own purposes, no check is made to determine whether the name given is genuine. Because of the way in which the clinics are funded, an individual receiving service need not be insured under OHIP. Dr. Wayne Linton, to whom I shall have occasion to refer again, the director of the venereal diseases clinic of St. Michael's Hospital in Toronto, testified that patients do not always give their true names or addresses. The falsehood is sometimes discovered when an attempt is made to trace a patient who has a positive blood test. If a patient is seen by a private physician, OHIP is billed for each visit. Dr. Linton testified that he lists the diagnosis as a related disease, such as non-specific urethritis, even though there is a separate diagnostic code for syphilis and gonorrhoea.

If a person is suspected of having syphilis a blood sample is taken. A swab from the infected area is taken from persons who may have gonorrhoea. All samples for tests for syphilis and gonorrhoea are supposed to be sent to one of the 12 provincial laboratories by mail or courier. Dr. Persad indicated at the hearings that some preliminary screening tests may be done by a hospital laboratory. Special treatment clinics enclose a group requisition with the samples sent to the provincial laboratories listing the names of the individuals only. Private physicians submit individual requisition forms with each sample, listing the patient's name, address, date of birth and sex.

After completing the tests the laboratory sends a copy of the report of all positive results of gonorrhoea and syphilis tests to the local medical officer of health, the Venereal Disease Section of the Ministry of Health and the treating physician. The laboratory may also telephone the treating physician so that treatment can be started as soon as possible. The laboratory report contains the names of the patient, the address, date of birth, sex, specimen type, physician's name and phone number and the results. All reports are sent by first class mail in envelopes marked "confidential". On receipt of the laboratory report the medical officer of health contacts a central registry at the Venereal Disease Control Section of the Ministry to see if the patient has been previously registered as having a venereal disease. If there is no previous registration and the physician has not registered the patient, the medical officer of health contacts the physician requesting him or her

to report the patient. The contact with the physician may be by telephone or letter. Only the medical officer of health may contact the central registry for patient information. Individual physicians must relay requests for past history through the medical officer of health.

Physicians report to the medical officer of health in writing, by completing a form for gonorrhoea or syphilis or by telephone, in which case the form is completed by a public health nurse employed by the medical officer of health. The syphilis registration form includes space for name, address, date of birth, sex, whether the patient is a contact of a case already registered and, if so, the name of the case, marital status, diagnosis, including biological false positive, site of infection, clinical and laboratory findings, treatment, previous treatment and contact information. The gonorrhoea registration form includes the same identifying information. The diagnoses listed include forms of gonorrhoea and non-specific urethritis.

Normally, contacts are traced by the patient's physician or a public health nurse employed by the medical officer of health who obtains contact information from the patient or from the physician. There are public health nurses at all special treatment clinics and all contact tracing at the clinics is done by them. If the contact is located out of the Province, the medical officer of health relays the information to Dr. Persad, who is responsible for follow-up if the contact lives in Canada. If the contact lives outside Canada, Dr. Persad forwards the information to the Department of National Health and Welfare for further action.

The medical officer of health maintains a file of completed registration forms and forwards a copy to the Venereal Disease Control Section of the Ministry of Health. The copies are sent by first class mail in envelopes marked "confidential". The laboratory reports received by the Ministry are date stamped and filed. The patient's name is checked against a card index which contains the names of all persons who have been previously registered as having a positive blood test for syphilis or diagnosed as having gonorrhoea. Every card refers to a file containing the results of each test, the name of the attending physician, diagnosis and the results of the serological tests. If there is a card, the file is located. If there is no card, the report is set aside until the registration form is received from the medical officer of health. The laboratory reports are used as a check to make sure that registration forms are filed for every positive result. Dr. Persad testified that before the laboratory reports were sent to the Ministry of Health there was no way to discover how many cases were not reported. He added

that it is "very common" for physicians not to report, "even though [they are] under an obligation to report".

All incoming registration forms received at the Venereal Disease Control Section are opened and date stamped by a mail clerk. Every registration form is assigned a unique number. The forms are given to Dr. Persad, who reviews them. Following the review they are passed on to a clerk who again checks the card index to see if the individual has been previously registered. The cards date back to 1909 and are purged only when death certificates are received with respect to persons who have died of complications from a venereal disease. Dr. Persad acknowledged that this purging is "hit or miss".

After Dr. Persad reviews the forms they are returned to a clerk who prepares a card for each case. They are then passed on to another clerk who ensures that the forms are properly completed in preparation for the computer. The information from the forms is then entered onto a computer cassette through a computer terminal in the Venereal Disease Control Section. The cassettes are saved for several days and then linked by telephone with the main computer where the information is merged with the master file.

After the file is merged, printed copies of the reports are returned through the printer attached to the terminal. These hard copy reports are then filed by the unique number. If there is a previous report, the new report is attached to it. The computer was introduced in 1974 so that if the previous case is post-1974 it is included on all subsequent hard copy reports. Reports prior to 1974 may not have been entered into the computer, although files from 1944 to 1974 are now being prepared for entry.

The brief of the Ministry of Health refers to what is perceived to be a difficult problem for physicians:

The physician often receives information which is of a personal nature. Most often this information is of use only to the physician and his patient. Instances do arise, however, where the examination of a patient reveals a possible future risk to the patient because of his environment (e.g. child abuse), or a risk to the health and safety of others. The doctor is then left with a serious dilemma and must weigh the requirements of confidentiality against his moral duty and responsibility to society.

The physician's decision-making is somewhat aided by legislation which is in place requiring such reporting, but still the decision to report is not one which is easily made.

In fact, however, there is no problem. Though he or she may be faced with an unpleasant task, the physician must report since most legislation which requires reporting imposes penalties on health-care providers for failure to do so. Section 152 of The Highway Traffic Act and section 12(1) of The Venereal Diseases Prevention Act provide for a maximum \$100 fine for the failure of a physician to report. Section 94(1)(f)(ii) of The Child Welfare Act, 1978 imposes a fine of up to \$1,000 for failure to report and section 118(2) of The Public Health Act a fine of up to \$2,000 or 6 months imprisonment, or both, for breach of the Act or regulations.

The Ministry of Health proposed the following four criteria in its brief to assist physicians in deciding when to report a disease or condition:

- 1) The situation being reported must be of high risk either to the patient, in the case of child abuse, or to the health and safety of the public, as in the case of a bus driver experiencing blackouts;
- 2) Reporting of the situation must be promptly followed by the introduction of measures of demonstrable usefulness in decreasing the risk(s);
- 3) Surveillance of the condition (usually on a statistical basis) is essential for effective control; and
- 4) Reporting of the condition is required by legislation.

Taken together, the first, second and third guidelines are another way of stating that the purpose of reporting must be considered. In other words, the information should be collected for the purpose of decreasing or avoiding a risk to an individual or society. According to Dr. Blake, the list of reportable diseases is reviewed regularly and limited to "ones that something can be done about, either for the patient or for his contacts or for the rest of the community." She gave an

example of the type of action that would be taken, for example, as a result of reporting measles:

...it is to try and keep under surveillance the contacts of the child, and this is normally a school, to try and round up the youngsters who have not been adequately immunized, or perhaps immunized with one of the older vaccines, to get them up to date and to hope that the immunization will work before the disease works.

I support the proposition that, as a minimum standard, reporting should not be required unless the information will be used for the benefit of the individual or the community. The benefit derived should outweigh the possible harm a person may suffer by the invasion of privacy.

The determination of the existence of a risk of harm to the individual or community sufficient to justify reporting should be governed by established criteria. The first is that the degree of risk to others must be weighed against the sensitivity of the information which must be released to avoid the risk. For example, if a disease is easily cured with no permanent effects it may not be justifiable to require a physician to disclose the names of his or her patients who have contracted the disease, particularly if there is a stigma attached to the disease. It cannot be assumed that any medical information is so innocuous that it can be released without risk. It must also be established that identifiable information is necessary to achieve the purpose for which it is required. In some instances statistical information may be sufficient for epidemiological studies.

The discussion of the venereal disease reporting system that follows is an attempt to apply the guidelines mentioned above to a mandatory reporting system. Knowledge of the existence of a venereal disease is generally considered to be more sensitive than that of other communicable diseases (although, in fact, it should perhaps be no more sensitive than such other types of reportable information as child abuse). The symptoms of influenza are observable by anybody and it is a disease which may be transmitted in a number of ways. Symptoms of venereal diseases are not always observable. Even the affected individual may be unaware of the existence of a venereal disease. Because it is a disease with a sexual connotation, knowledge that an individual has a venereal disease implies information about his or her private life that he or she may not want anyone

to know about. There is a social stigma attached to venereal diseases that is not attached to influenza.

From the point of view of public health officials, venereal diseases are serious and highly contagious diseases. Unlike other communicable diseases which may be spread by air-borne viruses or bacteria, venereal diseases are spread by sexual contact. A person having sexual contact with an infected person will almost definitely contract the disease. For this reason, a person who has had sexual contact with another diagnosed as having a venereal disease will be treated even though he or she may not have been positively diagnosed as having the disease.

Dr. Persad testified that out of the 23,000-24,000 registration forms received for gonorrhoea and syphilis annually, there are approximately 2,000 new cases of syphilis reported. Except for a small number of diseases other than gonorrhoea and syphilis, the remainder of the reports relate to gonorrhoea. Also of concern to public health officials is the fact that, in some persons, particularly women, a venereal disease may be asymptomatic; thus unless active contact tracing is undertaken, it may not be discovered and treated until permanent damage is done. There can be serious consequences, including death, if syphilis is untreated. The side effects from untreated gonorrhoea are less severe, but may still result in permanent physical damage to the reproductive system of the individual. Both diseases will cease being contagious after a period of time even without treatment. Since the discovery of penicillin and other modern antibiotics, syphilis and gonorrhoea can be successfully cured and, if treated promptly, will not result in any permanent effects.

Despite efforts of government and the medical profession the number of reported cases of venereal disease has risen over the past 15 years, although there was a slight decline from 1976 to 1977. Statistics prepared by the Ministry of Health and entered as an exhibit during the hearings show that in 1963 there were 41.0 cases of gonorrhoea per 100,000 persons, while in 1977 there were 195.9 reported cases of gonorrhoea per 100,000 persons. In 1963 there were 15.0 reported cases of syphilis per 100,000 persons, compared with 21.4 cases per 100,000 persons in 1977.

The Ministry of Health's brief stated two purposes for requiring the reporting of communicable diseases, including venereal diseases:

- 1) to prevent spread of diseases; and

- 2) for epidemiological studies of trends, prevalence, contributing factors, etc.

The brief also listed three purposes that had application only to the reporting of venereal diseases:

- 1) Sexually Transmitted Diseases (S.T.D.) are communicable diseases. In the interest of public health, the spread of these diseases should be controlled.
- 2) The most important aspect of any S.T.D. control programme is to ensure that the contacts of all cases are located as quickly as possible and brought to diagnosis and treatment. This approach reduces the reservoir of infection in the community, and limits the spread of the diseases. In order to accomplish this satisfactorily, the names of cases and contacts are required.
- 3) Many organizations and groups have frequently expressed some concern for the need for obtaining this information. There is general agreement that these diseases should be brought under control. There is general agreement in the epidemiological methodology to accomplish this, i.e. by contact follow-up.

At the hearings Dr. Persad outlined three purposes for the collection of information about venereal diseases. They were, (1) to assist in tracing contacts, (2) to make an accurate diagnosis, and (3) to compile statistical information. He said:

The main reason why we try to control these diseases is because they are infectious diseases, they are communicable diseases and we want to control them. One of the obvious ways to control any communicable disease is to find a source of the infection. And if you get to the source of the infection, the initial source or the spread contact. Someone can get gonorrhoea from somebody, or syphilis, and they can also spread gonorrhoea to somebody else. So there's a lot of people that are involved. So the purpose of

this really is just twofold. One is to assist in ensuring that all the cases are registered and all the contacts of these cases are found and located and brought to treatment. The second, which is probably to mind an equally or even more important reason is that once you have had syphilis, as I intimated earlier, the blood tests remain positive for the rest of the patient's life. The degree of positivity the amount of treatment received, five, ten, fifteen, twenty years ago, the patient's clinical examination, these are all things, considerations important in the clinical management of the patient. To determine whether the patient should be re-treated or other tests should be done or should be just kept under surveillance. And on a daily basis we receive calls from medical officers of health about patients whom they receive one of those lab tests, five, ten, or whatever it was, to know, do you know anything about this case. If you say fine, this was a man who was registered, he was in the war, he got syphilis, he was treated adequately, the serology will go one in two at that time. It is still one in two or one in one, whatever that means, he will say fine, we'll probably end the whole story right then. There will be no further need to use resources and look after contacts and things like that.

Whereas if we say the serology we know about this man was one in two in 1969 and the current report says it's one in a hundred and twenty-eight, which is a marked increase, this suggests to you there may be something happened between then and now. He would know that we would have to re-treat this patient, further investigate him, whatever.

For Dr. Persad, the tracing of contacts is the main reason for the collection of identifiable data. In his words:

...the main reason why we report the diseases is to control them and so that we can find the contacts in these cases. This

is a very basic sort of principle, because you get the source of the infection, that's so we can clean up the reservoir of infection in the community.

This position supports a statement made in the Report of the Task Force on Venereal Diseases, submitted in 1970 to the Honourable Thomas L. Wells, then Minister of Health, that:

The most important public health aspect of a venereal disease control programme must be directed to the location and examination of all contacts of each case as soon as possible after exposure has occurred, so that effective treatment can be instituted to minimize further spread of infection.

Sections 4 and 5 of The Venereal Diseases Prevention Act reflect the importance of tracing and treating contacts by giving a medical officer of health the power to order persons he believes to be infected to submit to an examination and to treatment. The following provisions of the Act are relevant:

4.(3) If by the report or certificate mentioned in subsection 1 it appears that the person so notified is infected with venereal disease, the medical officer of health may,

- (a) deliver to such person directions in the prescribed form as to the course of conduct to be pursued and may require such person to produce from time to time evidence satisfactory to the medical officer of health that he is undergoing adequate medical treatment and is in other respects carrying out such directions, and where such person fails to comply with the course of conduct prescribed for him or to produce the evidence required, the medical officer of health may exercise all the powers vested in him by clause (b) or may proceed under section 6; or

- (b) with the approval of the Minister, order in writing that such person be removed and detained in a place of detention for the prescribed treatment until such time as the medical officer of health is satisfied that an adequate degree of treatment has been attained.

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Section 5 (as amended by S.O. 1971, chapter 3, section 3) provides:

5.(1) Where,

- (a) any person has been named under oath as a source or contact of venereal disease or is believed by the medical officer of health to be a source or contact of such venereal disease; and
- (b) in the opinion of the medical officer of health the clinical findings and history of such person indicate that such person is or may be infected with venereal disease,

the medical officer of health may, whether or not laboratory findings indicate the presence of venereal disease, proceed in the manner prescribed in clauses (a) and (b) of subsection 3 of section 4.

The evidence at the hearings was that, despite the claim that the central registry is useful for contact tracing, it appears to play a small role in the procedure since the tracing, except for persons outside Ontario, is actually done by either the local medical officer of health to whom the case is reported or the patient's private physician. As explained earlier, it also plays no role in the case of persons who reside out of the Province. Regardless of who is tracing the contact, the registry itself does not provide any information. All that the tracer needs is the name of the contact and the diagnosis of the infected individual. Both are obtained from the treating physician. The name of the infected individual is not necessary

since, to protect the confidentiality of the source, it is not revealed to the contact. The only function served by the registry with respect to contact tracing relates to the checking of persons named as contacts against the names of persons on the registry to see if they are already being treated and therefore do not have to be traced. Despite his agreement that this is the basic reason for the maintenance of the system, Dr. Persad said that he had done no studies to determine the percentage of cases in which the information in the registry is useful and could make no estimate of the incidence of use of the registry for this purpose. This illustrates the gulf which can exist between information reported and the actual use that is made of it. If it is accepted that contact tracing is a valid purpose it may be necessary for the medical officer of health to receive identifiable data in order to discharge his or her obligations, but that does not necessarily justify sending the same information to a central registry having no responsibility for contact tracing. The use of information for tracing contacts does not seem to require long-term storage of the information. Once the contact has been traced and treated there is no continuing need for the information for that purpose. If the criteria recommended by the Ministry of Health are applied, the first one may be fulfilled--the situation reported may be of high risk--but the second (and possibly the third) is not fulfilled since the reporting to the registry is not followed by the introduction of measures of demonstrable usefulness in decreasing the risk.

The second purpose for the maintenance of a central registry--to assist in diagnosis--must be discussed separately for syphilis, on the one hand, and gonorrhoea, on the other, since the evidence indicated that, while it may have application to syphilis, there is some question as to its relevance to gonorrhoea. The laboratory diagnosis of syphilis is made by blood test. Blood samples are initially tested using the venereal disease research laboratory (VDRL) test. Positive samples are then subjected to three or more specific tests--kolmer reiter protein (KRP), treponema pallidum immobilization (TPI) and fluorescent treponema antibody (FTA).

The expert evidence at the hearings was that there is no specific test for syphilis since the organism itself cannot be grown from the blood sample. The VDRL is the least specific test and is used only as a screening test since its cost is much lower than that of the other tests. Dr. Persad testified that, "This [VDRL] is a screening test, I want to emphasize. It is not diagnostic and it isn't specifically a test for syphilis." Because it is a non-specific test, persons who have diseases other than syphilis may have a positive result. According to

Dr. Wayne Linton, another expert, yaws and several other diseases endemic to the tropics will cause a positive blood test. He said, "There is no way of, no test to differentiate them." Yaws is not a sexually-transmitted disease. Other diseases and conditions which can cause positive blood tests include rheumatic diseases such as arthritis, acute infections such as mononucleosis, pregnancy or a recent vaccination. Dr. Persad added that one per cent of the population may have a positive result for no known reason. Persons who have had syphilis, but who have been cured, may also have a positive blood test for a number of years after the original infection, although they are no longer contagious. The KRP, TPI and FTA tests, are more precise since they can identify the organism type, although not the syphilis organism specifically. These tests are not conclusive and may also result in false positives. It was Dr. Persad's evidence that "...it doesn't indicate the activity of the disease. It means you have or have had a treponemal infection." Thus a past treponemal infection, which is no longer positive, may still result in a positive result for many years. Dr. Persad also pointed out that the VDRL is the first test to become positive if an individual is infected and that the other tests may take as long as six months to become positive. Therefore, a positive VDRL with negative results from the other three tests is not necessarily, but may be, a false positive. Positive blood test results in persons who do not have syphilis are known as biological false positives.

It is not clear whether biological false positives must be reported. According to Dr. Persad there is no obligation on the physician to report a positive VDRL, but he added that:

Every positive laboratory test indicating or suggesting a diagnosis of venereal disease, the laboratory is obligated to send a copy of the report....

Another expert, Dr. Bruce Thomas, testified that, in his opinion, false positives must be reported, but that it was not always done:

I think that it would be reported in one way or another, yes. It may be sent in, it would not be necessarily reported the instant we got a positive test for syphilis or a positive serology, a positive non-specific test, a VDRL in other words. One would then have to do a, take this in combination with what the patient came complaining of, what the patient's symptoms

were, what the patient's signs were and a number of other investigations before we then decided what the problem was. Whether this indeed was syphilis or it was some other disease process. But there have been instances, I am sure, where the positive test was not reported. Yes. To get around to the answer in an indirect fashion.

False positive results that are reported to the Venereal Disease Control Section by physicians are filed on the venereal disease registry. The serological results are filed under the designation biological false positive.

The legislation requires only the reporting of a venereal disease as defined in The Venereal Diseases Prevention Act. Although a biological false positive is one of the choices listed under "diagnosis" on the reporting form, it is not by definition a venereal disease. No studies have been conducted as to the incidence of biological false positives in Ontario. Dr. Persad expressed the opinion that approximately five to eight per cent of the approximately two million tests done annually in Ontario result in a false positive. Dr. Bruce Thomas, the Medical Director of the Special Treatment Clinic at the Women's College Hospital in Toronto, estimated that between 10 and 20 per cent of all VDRL tests produce a false positive. Dr. Linton estimated that the rate of false positives was "somewhere around fifty percent of the patients."

A statistical summary prepared by the Ministry of Health for the period of January, 1977 to the week ending May 6, 1978, showed 69 reported biological false positives out of a total of 562 reported cases of syphilis--more than 11 per cent. According to Dr. Persad's evidence with respect to another statistical report which showed 70 false positives out of 300 cases of syphilis reported, these statistics may be misleading since one individual may have had more than one blood test within the period reported. He said that there were no statistics of the number of false positives, but added, "...I am sure it's not as high as thirty percent."

Dr. Persad testified that several studies have been conducted with respect to the development of syphilis. The studies, he said, demonstrated that in approximately one-third of the cases:

...the disease will burn itself out and they will have no after effects, no blood tests

will be positive, it won't affect their longevity or anything at all.

Another third will continue to have positive blood tests for the rest of their lives, but the disease would have no serious effects on them. They would live their normal three score and ten plus.

The final third of these people who contracted the disease, you would get the rather serious complications of the disease.

But getting a positive test, one doesn't know which third you belong to and these people have to be followed up...

Audrey Cummins, the Supervisor of the Venereal Disease Control Section of the Ministry of Health, estimated during the hearings that medical officers of health requested information on approximately 200 cases of syphilis weekly.

Another reason advanced by Dr. Persad for the importance of a registry containing biological false positives is that physicians often treat patients inadequately and that, in addition to assisting the physicians in making a diagnosis, the registry enables him to monitor physicians to ensure proper diagnosis and treatment. During a discussion of this point at the hearings the following exchange occurred after Mr. Strosberg had referred to the views which had been expressed to him by Dr. Thomas:

MR. STROSBERG: As I understand what his [Dr. Thomas's] evidence is going to be, it is to the effect that the type of information that you have just described certainly might be useful in the purpose in clinically confirming the diagnosis of syphilis, but a good clinician really does not need that information to make a diagnosis?

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MR. COMMISSIONER: Start at the beginning of that.

MR. STROSBERG: That it might be useful for a physician to have the information which

you have described, for example whether or not there has been a change in serology, but that a physician who is able to make a clinical diagnosis doesn't need that information?

DR. PERSAD: On balance that's a not unreasonable position, but that's assuming that you have physicians, and I hate to say this in open court, who are extremely competent in treating venereal diseases. I would like to suggest that the quality of clinical expertise that is available for the diagnosis and treatment of venereal diseases is not of that quality that you are talking about. Ideally, yes. In the United Kingdom they don't have any reporting and keeping that information on file, simply because...

MR. COMMISSIONER: They don't?

DR. PERSAD: They don't. Simply because they are practising an entirely different contact, in a different environment of medical practice.

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DR. PERSAD: Last year I did a survey to try to determine the level of medical competence in Ontario on the diagnosis and treatment of venereal diseases. I first of all wrote to all the medical libraries in the province trying to determine what type of reference texts they had, using this as one index of the level of the teaching of the subject. One of the very famous medical schools, the latest book they had on treatment of venereal diseases was a book called Modern Clinical Syphilology by a man called Stokes and Bergman, published in 1946. That was their reference book and this is a collector's item, although I have one. Then I prepared a questionnaire of fifty very simple questions which I thought were elementary regarding the diagnosis and treatment of the disease, of the diagnosing of syphilis, treatment and so forth. And which, I checked it with some of my

colleagues and anticipated that there should be a minimum of seventy percent scored on that. And I administered it to about three hundred practising physicians and three hundred-odd students about to write the LMCC examination, the qualifying medical examination. They uniformly scored just about thirty-five, forty percent on it.

So at that stage I was charitable and said maybe one isn't expected to carry this information off the top of his head, what's the treatment for gonorrhoea. If you are in your office and you don't know how to treat the patient why you go in the other room on the pretext of washing your hands and look it up in the book and go and treat your patient.

We examined one thousand of these forms on which one has to indicate the treatment that he has given to the patient. About two months before I did that, I sent out the treatment schedule to all the practising physicians in Ontario, which means that they might have been exposed. They might have thrown it in the basket, but they were exposed to it. And fully sixty percent of the patients who were treated by private physicians were either inadequately or not properly treated.

Now that is some sort of a reflection on the kind of clinical competence you are talking about. If we had that, I wouldn't worry about it.

While Dr. Linton and Dr. Thomas, who testified as expert witnesses, agreed that the information could be useful in the way described by Dr. Persad to assist in diagnosis, Dr. Linton thought that reason was sufficient to justify the system, and Dr. Thomas did not agree that the information was vital. Dr. Linton has been the director of the venereal diseases clinic at St. Michael's Hospital for 15 years. He is also an assistant professor at the University of Toronto. St. Michael's Hospital's clinic is the second largest clinic in the city of Toronto, with approximately 500 to 550 patients monthly. Dr. Linton also has a private practice. His evidence was that he would use the central registry to determine whether or not a

patient diagnosed as having syphilis had ever had a positive blood test in the past. He said that because it was available, it was used frequently by the clinic, particularly to check on persons who come in with a vague history of past treatment:

Anyone who has a VDRL and a KRP, which is simply a verification test, that are both positive and there is no specific history on the part of the patient of having been treated for syphilis, then I would ask for any information from a family doctor or a registry if they have a, if they aren't registered then I would ask if there was a family doctor who might have done tests in the past to find out when the patient last had a negative test or whether they have always had a positive test.

MR. STROSBURG: What is your best estimate as to the number, the percentage of cases that you treat where you would be making that type of inquiry?

DR. LINTON: In the clinic we make it very frequently probably, because it is available to us. Also because many of our patients who come in are patients who give a vague history of some treatment while they were in jail, so forth. These patients have had some form of treatment. They don't know how much they have had or whether for sure it was for syphilis or something else. Those patients we do inquire about.

MR. STROSBURG: Do you believe then that a central registry which maintains a record of those persons who have had syphilis ought to be maintained in the province?

DR. LINTON: Yes. Definitely. If they have had syphilis, I think it should be maintained.

Dr. Linton later said:

I think there can be a lot of harm by keeping records of venereal disease or it leaking out. Syphilis is the one disease though where there is a great deal of

difficulty in the diagnosis of the disease and because the tests so often remain positive for the rest of a patient's life. A woman has syphilis, is adequately treated in her late teens, marries, her blood test stays weakly positive. She gets pregnant. I have heard doctors who have dealt with syphilis, quite a bit of syphilis in the past, say that they have had a resurgence of their syphilis because their blood test takes a jump of two tubes, from one in two to one in eight or one in sixteen. Yet all this is is a manifestation of the added strain on the body from the pregnancy. Certainly if you kill a bug it can't spontaneously generate gain. But, there again there is the other argument that is often used is we have to treat her anyway because maybe she did get syphilis again and you have to protect the baby.

Syphilis is a very, very difficult disease because of the lack of adequate tests to tell us when the patient is cured or whether they actually ever had it or whether they had yaws as a child in Jamaica, received one shot of penicillin and were cured.

In the final analysis, Dr. Linton justified retaining the system because of the severity of the disease:

Because one person in four who is inadequately treated goes on to late manifestation of syphilis. At one time it was one of the biggest causes of people being in mental institutions and so forth, so there are, the late problems are sufficiently severe I think that it warrants keeping records of syphilitics, you know, for their lifetime.

However, he added the caveat that the registry should be restricted to those with positive VDRL and KRP, since a KRP is automatically done on all patients who have a positive VDRL. If the KRP is not positive, there is no chance that the patient will be considered by a physician to have syphilis.

Dr. Thomas has been associated with the Women's College Hospital's special treatment clinic for approximately ten years,

and has been the director for the past five years. The clinic operates four days a week, and sees between 20 and 40 patients daily. Although his clinic contacts the ministry several times a week to learn whether or not a patient has been previously treated for syphilis, Dr. Thomas was of the opinion that, while it is helpful, that alone did not justify the maintenance of a central registry:

...it is helpful from the individual person's point of view. It is a helpful bit of information. I am not saying this is the only way it might be obtained, but it is a helpful bit of information in the sense that one of the common presentations of someone to the clinic or to their family doctor with syphilis is someone apparently well with no history who has a positive VDRL. And one of the first things we would do is okay, there is a central registry, let's call up and check and see if he is registered as a previously treated case.

MR. STROSBURG: I asked whether you felt in your judgment that function justified the maintenance of a central registry?

DR. THOMAS: To my mind that function alone would not.

Dr. Thomas suggested that competent physicians have methods of obtaining the same or similar information. He recommended developing a system in which patients carry a letter or card notifying any future physicians that they have been diagnosed and treated for syphilis in the past. He said that on several occasions he had given patients letters stating that they have a false positive blood test, but did not have the disease. He has done this to avoid registering them on the system since biological false positives need not be registered.

The case of gonorrhoea is quite different because of the nature of the infection. It is possible to culture the organism which causes gonorrhoea from the specimen sent to the laboratory. Thus, if the test shows a positive result it means that there is an active infection. Persons who have been successfully treated for the disease will have a negative test result unless there is any active infection left in which case treatment is necessary. There is no need for a physician to know whether a patient has had a positive gonorrhoea test in the past since it has no effect on whether or not there is infection

present. Dr. Persad explained that "With gonorrhoea if you're treated, you're completely cured and that episode comes to an end."

Dr. Thomas testified that he has never had an occasion to request information about gonorrhoea from the registry since a full cure is effected after treatment:

Well in the vast majority of instances it is a minor disease in the sense that as far as permanent sequelae are concerned or follow-up problems, they don't normally occur because it's an isolated disease that's treated and the patient usually leaves well. So they don't have any stigma so to speak of in their blood that they have had this disease in the past.

Dr. Linton's evidence with respect to the records for gonorrhoea was that in his opinion they should be maintained no longer than one year since they serve no diagnostic purpose. He added that after a few months even a person who was not treated will cease to be infectious although he or she may suffer from complications. He said that the registry might prove useful in determining whether or not a patient's contact had, in fact, been diagnosed as having gonorrhoea and had been treated, but once the tracing was completed there was no further use for the record. Dr. Persad also testified that no calls were received about the previous treatment of gonorrhoea since all positive tests indicated new infection which must be treated regardless of past treatment. He agreed that there was no need to report gonorrhoea for the purpose of aiding in diagnosis and expressed doubt about the necessity of reporting:

There is a point of view that is expressed by many prestigious groups, like the Canadian Bar Association...I put them at the top, sir...the Canadian Medical Association, the Ontario Medical Association. They suggest that we, there is no need, in just as many words, to report gonorrhoea. I could entertain that point of view, but they never have suggested what do you do instead of that. If you don't report it, are we just to have no control and just hope and keep your fingers crossed and hope that the disease will be controlled, and I'm sure that will not happen.

Dr. Persad said that the real purpose of reporting gonorrhoea was to assist in contact tracing. However, he gave no estimate of the number of cases in which the name of the contact was checked on the registry. He testified that if a physician knew where the contact resided he could contact the local medical officer of health directly to see if there had been a report. If the contact lived outside Ontario there would be no report in any case. It may be that the registry can be checked to see if a contact has been treated. It is important, in this case, to know how important that use actually is. The conflicting interests can only be balanced when one is able to assess the importance of each. The paucity of information makes it impossible to know whether the use of the registry for this purpose is sufficient to justify maintaining a central registry containing the names of persons afflicted with a disease carrying a social stigma in the minds of many members of society.

Testimony given by Dr. Persad and Dr. G. Martin, Executive Director of the Health Programmes Division of the Ministry of Health, about the effect of false names on the efficiency of the registry also raises doubt about the need for identifiable reporting. Patients seen at clinics do not always give their real names since no identification is required. Dr. Persad agreed that a number of "John Does" may be reported, but he added:

We want to find the contacts. The chief reason why we operate the clinics, the most important reason, is not to treat these people, but to find the contacts. To use it as a base to interview them for contact information. If we have five hundred John Does, we get the correct Mary Jane Smith or Mary Jane Stephenson, we really don't mind.

MISS SMITH: You feel that the contact tracing is the most important aspect, not the treatment?

DR. PERSAD: Yes. Most certainly. We use the clinics as a base for interviewing cases to find the contacts.

MR. COMMISSIONER: I take it the reason for that way of putting it is that you know they are being treated, because that's why they are at the clinic.

DR. PERSAD: Yes. We know that they are there, we know that they are treated, they are cured. Fine. They can't spread it to anybody else. But once we have them there, we find out the source where it came from.

As well as making it impossible to use the registry in any way for contact tracing, having "John Does" registered interferes with the second purpose, which is to provide assistance to physicians who have a patient with a positive blood test for syphilis. If a patient does not give his true name there is no way to check the registry to find out whether the patient has previously been treated unless he or she continues to use the same false name. Thus, the stated purposes, to trace contacts, and to assist in diagnosing venereal disease are achieved only in part through the use of a central registry. The registry, particularly with respect to gonorrhoea, does not seem to be essential to achieve the purposes. This highlights the policy issues which must be considered. The first question to be answered is whether the stated purposes are sufficient to justify breach of confidentiality, taking into account the sensitivity of the information. The next question is whether the information is, in fact, necessary to achieve the purposes. In my view, the fundamental proposition is that no unnecessary information should be required to be reported and no more information than is essential should be collected.

Gonorrhoea reporting is not the only example of a case in which the purpose is not of sufficient importance to warrant reporting, or in which the purpose can be achieved without reporting. Both the gonorrhoea and syphilis registration forms contain a space marked "epidemiological". Dr. Thomas explained that an epidemiological case was one in which an individual is a known contact of an infected person and is treated as having the infection although the laboratory tests may not have been done or, if done, give no indication of disease. Thus, persons are registered on the system even though it cannot be said, in fact, that they have a venereal disease. Since no explanation of why this information is necessary was given it may be assumed that it falls within the stated purposes of assisting with the diagnosis and contact tracing. Another example is the diagnostic category on the syphilis registration form designated NSU-non-specific urethritis, which is not listed among the reportable diseases under The Venereal Diseases Prevention Act. Dr. Persad testified that it was included in anticipation of a change in the legislation to include NSU. At the present time, he testified, few doctors report it. He estimates that "There must have been more cases of NSU in Ontario than gonorrhoea" but the statistics show few reported cases.

The discussion which follows illustrates the principle that making a disease reportable is not in itself a sufficient justification for the collection of the resulting information. Dr. Persad testified that NSU is now recognized as a sexually-transmitted disease. It was his evidence that according to some authorities it is only transmissible through sexual contact:

The reason being we, when about twenty years ago we thought that all urethral discharges were gonorrhoea. That's all we knew. And if it wasn't gonorrhoea we called it non-gonococcal urethritis. Now we know that non-specific urethritis is a clinical entity and is caused by, we have identified an organism that causes it, chlamydia trachomatis.

One of the recommendations would be that we are making this change of term venereal disease to the much more meaningful term of sexually transmitted diseases and look at this, this is spread from person to person the same way, by sexual intercourse.

Dr. Thomas said that NSU was not reported from his clinic. His definition differed from Dr. Persad's:

It's basically a term which simply means a urethral discharge in the male that isn't caused by the gonococcus, the organism which causes gonorrhoea.

He disagreed that it must be sexually transmitted or that it is caused by one organism:

I think in some instances it is, yes. But I think to say that it's caused by a single organism in the sense that gonorrhoea is a specific disease, no. I don't believe so. I think it, in some instances it is the result of a chemical irritation. In some instances it may be the result of a trauma from repeated intercourse and in other instances it is an infectious thing, but a large number of organisms have been implicated.

Dr. Linton agreed that NSU should not be a reportable disease:

In issue is a male disease, it seems to be harmless except for the nuisance value of the disease and it certainly recurs once a patient has had it, without sexual contact. So I can see no reason to, there is no advantage in my knowing whether somebody has had contact with an NSU.

No evidence was given that, even if NSU is sexually transmitted, there is a need for contact tracing or for past information for diagnostic or treatment purposes. At the present time, non-specific urethritis cannot be considered a reportable disease under the existing legislation. Before a decision is made to include it in any future legislation there should be a more intensive examination of the purpose of reporting it. According to the evidence given the collection serves no purpose except, perhaps, for research. This demonstrates the need to consider individually each disease or condition which should be reported. Simply stating that a disease falls within a generic category is not sufficient.

On a more general level, Dr. Persad discussed the purpose of venereal disease reporting. His testimony casts doubt on the necessity of requiring venereal disease reporting, particularly gonorrhoea, in an identifiable form on a universal basis. He said:

You earlier raised the concept that total reporting is what must be aimed at. We find that in venereal diseases, in particular, something less than total reporting may be just as adequate. They have worked out mathematical models whereby if you get just a small percentage, about thirty percent of the cases...reported in a community, and religiously follow those down, and the community doesn't increase any more, in a period of about a year, you would reduce that thousand cases, let's say of VD, in that community to something like thirty-nine cases. These are just theoretical models.

So the concept that complete reporting is absolutely essential is not really very valid.

Dr. Martin disputed Dr. Persad's figures but said:

Again, we'll get different theories. I don't know whether a model that talks about thirty percent reporting reducing the incidence sixty-one percent in a year is a valid model or not. I would think not. The same as many models we tried for rapid contact investigation have invariably failed through the course of the years, and haven't a model that's going to work as yet.

Dr. Persad also said:

The ones that do report are the ones from the clinic, patients who are likely to form the reservoir of infection, and we get those in, they have to be reported more than the forty-five year old businessman who goes to Montreal and picks up a dose of gonorrhoea and comes back. He really is no epidemiological significance when he comes back here. We call him an inefficient transmitter of the disease. Whereas with a nineteen year old who goes to the clinic or to a physician who is not his family doctor, he is likely to get reported, and he will be classified as an efficient transmitter.

Dr. Martin added:

I think really what we are homing in on is that we must continue to have mechanisms which will allow and encourage the clinics to report at the hundred percent level. As we see a higher percentage of our patients served by the clinics, then at least that portion of the reservoir is going to be looked after epidemiologically.

Underlying the discussion is a recognition of the competing interests faced by those responsible for the treatment of venereal disease. On the one hand, it is important to treat the disease and all contacts. This is the primary goal. However, there is also a recognized need to collect information. The very collection of information may prevent persons from receiving treatment. The concern about the confidentiality of information is one which was expressed by the physicians testifying and is reflected in the speculation that individuals

attending at clinics do not use their real names. Dr. Linton admitted that he does not always report his private patients because of his fears about the security of the system. He said:

It is not necessarily important that the fears are not based on actual occurrences. Those responsible for determining whether venereal diseases should be reported must consider whether the appearance of a risk is deterring treatment.

This point of view prevailed in Great Britain where there is no central reporting scheme. In a letter from the Department of Health and Social Security in London, England, describing the venereal disease reporting system in England and Wales, we were advised that the decision was made in 1947 to discontinue the identifiable reporting to a central authority which had been implemented in 1942 because of complaints by physicians that it encroached on their confidential relationship:

Very few cases were in fact notified centrally, and the failure of this attempt to introduce control strengthened the view taken by post-war Governments that it would be counter-productive to seek to impose any element of compulsion or notification into treatment. It is felt that the best guarantee that sufferers will attend for treatment is the knowledge that all details will be absolutely confidential within the clinic.

So much for policy considerations for compulsory reporting. Once it has been decided that information should be collected, its physical security must be assured. The level and specific type of precautions needed vary depending on the sensitivity of the information and the use to which it is put. Security includes access to the information as well as the physical security surrounding the collection, storage and destruction of the information. The most important prerequisite of adequate security is an awareness by the staff that the information is sensitive and must be protected and that any standards are only minimum standards, not prescriptions.

The evidence given by Dr. Persad and Mrs. Cummins indicates their high regard for, and sensitivity to, confidentiality. Yet there were several weak spots which did come to our attention. I refer to them not as criticism of Dr. Persad or Mrs. Cummins,

for they deserve only commendation, but to demonstrate the necessity for examining every stage in detail. One concern is the practice of mailing laboratory reports containing identifiable diagnostic information to the medical officers of health and the Ministry of Health. Although the envelopes are marked confidential, they are out of the control of responsible personnel for a period of time and could be tampered with or abused or simply lost.

The layout of the Venereal Disease Control Section illustrates another concern, that of physical security. The section is not enclosed. Direct access is possible from the elevator area and there is no door or any other method of enclosing the section after hours. The filing cabinets containing all the files of reported cases are kept in this open area. There are no special locks on any of the cabinets, only those provided by the manufacturer. It is our experience that those locks can easily be opened by a hairpin and that often one key will work in several cabinets made by the same manufacturer.

The computer terminal and filing cabinet which holds the cassettes onto which reports are transcribed daily and the tape containing instructions for obtaining access to the terminal are in a separate room with a door. However, the walls are open from above the door to the ceiling. An intruder could enter the room by climbing over the top. As with the cabinets in the outer office, those in the room with the computer terminal have no special lock. Thus, there is access to all parts of the Venereal Disease Control Section without the use of a key, although entry to the computer area is only by climbing over the wall.

Open access is significant since it not only permits intruders who can by-pass initial security at the main door to enter the area, but it allows employees who are in the building by virtue of their status, but who are not authorized to enter the area, to do so after hours with no difficulty. The allegations made about the abuse of the venereal disease system were made with respect to unauthorized access by an employee. Information must be protected against unauthorized access by employees as well as by outsiders.

With relation to other aspects of physical security, the section exercised considerable caution. Mrs. Cummins testified that all documents are locked in cabinets at night. The responsibility for ensuring that the cabinets are locked at night has been expressly made that of a member of the staff. Disposal of material is supervised. According to Mrs. Cummins,

all documents, including telephone messages with identifiable information on them are torn up into small pieces and put in a box designated "confidential garbage". The box is sealed and disposed of by someone from the records branch of the Ministry of Health. The training of staff is an important component of security. Mrs. Cummins testified that the importance of confidentiality is impressed on all new employees and they all work in close physical proximity to each other so that direct supervision is possible.

Information from the central registry is not given to a caller directly. All persons are called back to check the identity of the caller. The only exception to the rule is in the case of an emergency. Mrs. Cummins explained:

...I know each nurse. I have been advised if there is a change, I am advised of a name. The usual procedure is to hang up, to have them looked up and I call the nurse back, unless, if there is an emergency, which we do have, with a high serology rate, I know the nurses. I know the voices. I know who I am speaking to. I trained for that. That is my position.

Of more concern than the physical security is that more information is stored than is necessary. By keeping records that are no longer necessary, or maintaining extra copies of reports, there is an increased possibility that someone could obtain unauthorized access to the information simply because there is more information to obtain access to. Two sets of records are kept, one on computer tape and the other as a hard copy printout from the tape. Both sets of records contain the names of the individual patients as well as a unique identifying number assigned to each case. The manual and computer records are filed by number. The card index is a third set of records which also contains identifiable information including diagnosis.

Dr. Persad originally said that both the name and the unique identifying number were necessary on the computer tape and hard copy because, "...I think it would be so much easier to have it right there in front of you when you are talking to [the medical officer of health]." But later Dr. Persad agreed that the name was not necessary. He testified that the hard copy is used to give information to the medical officer of health and that the computer is "...used for two things, to get all the data into a hard form you print it out on a file and to churn out these statistical demographic tables and charts...."

The following discussion between Mr. Strosberg and Dr. Persad is instructive:

Q. Really what you have then is you have a duplication of systems?

A. It sounds like it, yes.

Q. Yes. You have a computerized system which contains all of the very same information that is maintained in the hard copy form?

A. Yes. Aren't you overlooking one of the reasons I mentioned for having the computer system? It was made to a large extent for the collection of statistics and demographic data.

Q. Yes?

A. When this was introduced the reason was, probably the main reason at that time wasn't for this type of names sort of thing. Like we store them all on cards first of all. You know those cards with the holes all the way around of them, and you want to know how many seventeen years olds there were in Barrie with syphilis?

Q. Yes? We stuck a wire in there and shook them all up and they all fell on the floor and you got one out of it, and you want to know how many male seventeen year olds there were, and this is why we couldn't really count it up that way and this is what the need was.

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A. I suppose for the sake of confidentiality these records are secure within the section itself. My own preference would be not to have the stuff come in from downstairs in the computer or anywhere else.

Q. Isn't that just because, like all of us, you distrust that, you like to see your

files there? You like to be able to put your hands on them and that's the reason that you say that?

A. Yes. Sure.

Q. But in terms of efficiency and efficient operation you could just as easily use a computer line, if it was made available to you on the basis that I just put it to you?

A. Yes.

Later in the proceedings, Dr. Persad said that, as a general rule, the medical officer of health could wait the two or three days it takes to get information from the computer if requests were made in batches.

While there is no evidence that any harm has resulted from maintaining two parallel systems, the sensitivity of the information makes it necessary to maintain the highest possible degree of security, which includes keeping only as much identifiable information as is necessary for the purpose served by the system.

Finally, and at the risk of repetition of one of the underlying themes of this report, I express the view that the relationship of confidence between patients and health-care providers has a functional as well as an ethical justification and should only be interfered with by the state in the case of compelling need. A decision to require health-care providers to breach the confidence is one that should be made only after a careful consideration and one that receives the endorsement of the Legislature to ensure an opportunity to debate the need for it.

Recommendations:

97. *That all persons about whom a mandatory report is made be informed, by the recipient, of the fact that a report has been filed and of the nature of the content of the report. The name of the person filing the report and other identifying characteristics of the information may be deleted if the report was made in confidence.*

98. That legislation requiring reporting by health-care providers not be enacted unless the following circumstances exist:
- (a) the information, in an identifiable form, is necessary to protect the health and well-being of the public or a substantial number of members of the public;
 - (b) there is no other method by which the purpose could be accomplished; and
 - (c) the benefit to the public or members of the public sought to be protected outweighs the risk to the subjects of the reports from the invasion of their privacy.
99. That the Deputy Minister of Health or a designated official of the Ministry responsible for the collection of the information review, annually, all reporting requirements to determine:
- (a) whether the purpose of the reporting requirement remains valid;
 - (b) whether the information actually being collected is in accordance with the purpose of the reporting requirement;
 - (c) whether the information is being used in a manner consistent with the purpose of the reporting requirement; and
 - (d) whether any alternative methods of achieving the purpose of the reporting requirement without using identifiable information are possible.
100. That all mandatory reporting legislation contain a provision that the

information collected is confidential and is not to be disclosed to any third party not expressly authorized by the legislation unless the law otherwise requires.

101. That the subject of a report have the right to request that errors be corrected. If the collector of the information is of the opinion that no correction should be made, a record of the dispute should be attached to the original record and included when a disclosure of the original record is made.
102. That the method of physical security adopted for the information collected reflect the sensitivity of that information in accordance with the following rules:
 - (a) only as much information in a personally identifiable form as is necessary to fulfil the purpose of the reporting requirement shall be collected and maintained;
 - (b) personally identifiable information should be destroyed as soon as it is no longer useful. Retention schedules should be drawn up taking into account the purpose for which the information is collected; and
 - (c) records that are to be stored, such as, for example, communications from a laboratory to a medical officer of health, should be transferred in such a manner that they are never out of the control of a person responsible for their security.
103. That, in the light of the evidence that the purpose for which cases of gonorrhoea must be reported may no longer justify the risk from the

invasion of privacy, the requirement of reporting them be carefully and objectively reconsidered.

APPENDIX

MANDATORY REPORTING OF HEALTH INFORMATION

The following Acts and regulations require health-care providers, on their own initiative, to report communicable diseases and conditions or diseases which, though not communicable, may affect the health and safety of the subject or others:

Sections 11, 14(4)(d) of Regulation 85 (as am. O Reg. 387/76, s.2, O. Reg. 769/78, s.1) made under The Charitable Institutions Act, R.S.O. 1970, c.62.

The Child Welfare Act, 1978, S.O. 1978, c.85, section 49(1),(2), (3).

Section 12 of Regulation 88 made under The Children's Institutions Act, 1978, S.O. 1978, c.69.

Section 17 of O. Reg. 382/79 made under The Children's Residential Services Act, 1978, S.O. 1978, c.70.

The Coroner's Act, 1972, S.O. 1978, c.98, as am. S.O. 1978, c.38, s.4, section 9(1),(2),(3).

The Highway Traffic Act, R.S.O. 1970, c.202, sections 143(1), 144(1).

Sections 5(r), 18(4)(d) of Regulation 439 (as as. O. Reg. 770/78, s.2) made under The Homes for the Aged and Rest Homes Act, R.S.O. 1970, c.206, as. am. S.O. 1972, c.62, s.2(2).

Section 10 of Regulation 437 (as am. O. Reg. 439/74, s.7) made under The Homes for Retarded Persons Act, R.S.O. 1970, c.204.

The Ministry of Correctional Services Act, 1978, S.O. 1978, c.37, section 24(1),(2) and section 6 of O. Reg. 243/79 thereunder.

Sections 74(1), 91(5) of O. Reg. 196/72 made under The Nursing Homes Act, 1972, S.O. 1972, c.11.

The Private Hospitals Act, R.S.O. 1970, c.361, as am. S.O. 1973, c.123, section 28 and sections 17, 18 of Regulation 689 (as am. O. Reg. 417/71, c.2) thereunder.

The Public Health Act, R.S.O. 1970, c.377, sections 59, 63(4), (5), 64 and section 59 of Regulation 701, sections 9(1), 14, 16, 18(3), 22, 23, 24 of Regulation 703 and section 7(c) of O. Reg. 483/72 thereunder.

Sections 24(3), 57, 58 of Regulation 729 made under The Public Hospitals Act, R.S.O. 1970, c.378, as am. S.O. 1972, c.90.

The Sanatoria for Consumptives Act, R.S.O. 1970, c.422, as am. S.O. 1972, c.94, section 47.

Sections 20, 22(b),(c) of O. Reg. 384/79 made under The Training Schools Act, R.S.O. 1970, c.467, as am. S.O. 1978, c.66.

The Venereal Diseases Prevention Act, R.S.O. 1970, c.479, as am. S.O. 1971, Vol.2, c.33, s.3, sections 3(1), 7, 10, 19(c) and section 7 of Regulation 819 thereunder.

The Vital Statistics Act, R.S.O. 1970, c.483, as am. S.O. 1973, c.114, ss.1, 5, Sections 5(1),(2), 8(1), 14(2),(3), 17(3),(4).

Student Health Information

In Canada, the last several years have seen an increasing public awareness of, and sensitivity concerning, the collection of personal information dealing with students. There has been an increasing public concern about intrusions into the confidentiality of health records. Moreover, although there may be access to school children's health information on the part of government, social and health agencies, researchers, and educators, the parents of these children have been prevented from knowing the nature of the contents of the files and the actual information which they contain.

The existence of a variety of legislative provisions aimed at direct health-care providers, such as physicians, nurses and hospitals, does not provide adequate assurance that the confidentiality of school children's health records will be protected. At the present time, statutory and regulatory provisions provide little or no public accountability for the administrative decisions made by both public health and educational authorities about the information that is collected.

The health records of students in post-secondary educational institutions are not dealt with here. We discovered very little evidence that there were significant problems in these institutions. There are at least two respects in which they differ from primary and secondary schools. First, most post-secondary school students are regarded as adults for health care purposes, and, accordingly, the institutions deal directly with the students. The post-secondary school administration does not perceive itself as standing in loco parentis to the same extent as the public and secondary school administrations do. Second, the public health services applicable to post-secondary students are generally those available to the broader adult community and do not concern themselves with such matters as identification of early learning problems and immunization of young children.

Although no specific abuses in connection with health records in post-secondary school institutions were brought to my attention, I did receive a submission expressing concern about

the amount of confidential health information that may be required by a post-secondary school at the time of the student's application for admission. The submission dealt with the amount and variety of information that is asked for, which, in the writer's opinion, had little or nothing to do with admission or enrolment. The writer was worried about the manner of storing the completed reports. He went on to compare the insistence upon these forms and the type of questions asked to the pre-employment situation. My recommendations with respect to medical information obtained for pre-employment purposes apply equally to such information obtained or required for pre-enrolment purposes.

In Ontario, there are 194 school boards, including public and secondary school boards and separate school boards. Of the 194 boards of education, 185 are active boards and 9 boards are inactive, that is, serving no school population for the time being. The boards serve a total public and high school population of approximately 1,913,995 children in 4,928 public, secondary and special schools.

The Education Act, 1974, S.O. 1974, chapter 109, provides the statutory authority for the duties of a principal of a school, more particularly set out in section 230 of that Act. Among those duties are the following:

- (d) to establish and maintain, and to retain, transfer and dispose of, in the manner prescribed by the regulations, a record in respect of each pupil enrolled in the school;

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- (j) to give assiduous attention to the health and comfort of the pupils, to the cleanliness, temperature and ventilation of the school, to the care of all teaching materials and other school property, and to the condition and appearance of the school buildings and grounds. [emphasis added]

Section 231 of the Act contains provisions with respect to the maintenance of pupil records, creates a statutory privilege in favour of the supervisory officers, principal and teachers of the school, provides a right on the part of a pupil, and his or her parents or guardian where the pupil is a minor, to examine the record and to request the correction of inaccuracies in a

student record, allows the compilation and delivery of such information as may be required by the Minister of Education or the board of education, and provides for the confidentiality of the record.

School authorities are granted a broad discretion with respect to the gathering, recording and use of information about students without the consent of the students or their parents. This information gathering is obviously essential if schools are to provide all the services required of them. The statutory duties imposed upon principals and boards of education are supplemented by a common law tradition requiring a high standard of care in relation to pupils. A long line of case law indicates the very high standard of care and protection required. Williams v. Eady (1893), 10 Times Law Reports 41, is an early example:

The school master was bound to take such care of his students as a careful father would take of his boys and there could not be a better definition of the duty of a school master.

This standard has been adopted and applied in a number of decided cases including several in the Supreme Court of Canada.

The nature of this relationship was referred to and relied upon in the brief submitted by the Board of Education for the City of Toronto. I accept the proposition that, generally speaking, in some situations, school principals and boards of education may not only have the authority, but may even be required, to act in loco parentis with respect to their students. However, I do not accept the submission made to me that the relationship between the school authorities and the student can be extended to give to the school authorities an unqualified right to any and all information they may deem necessary, even where to do so may be contrary to the desires and wishes of a responsible parent. In other words, some of the issues raised before me regarding the confidentiality of health information with respect to pupils are not necessarily determined by the characterization of the relationship between school authorities and students as being that of a concerned parent to his or her child. Other factors must be taken into consideration before a determination can be made of the best interests of the child, other school children, and society as a whole.

It has been an assumption of those educators who appeared before me that the health status of a child plays a major part

in learning, and, accordingly, that various types of health information are essential to the ability to carry out the statutory and common law obligations of school authorities to their students. These assumptions have had a clear impact on the form of student record keeping by school authorities in Ontario, on the delivery of a variety of health services to students, and on the gathering, recording and use of health information which is directly or indirectly related to the provision of the perceived educational requirements of individual students.

The accumulation of health information about students serves a number of purposes. The boards of education and individual schools have generally interpreted their legal responsibility to consist of obtaining basic health information at the time a child enters the school system. This is to be provided by a report from the child's family physician. In the absence of such a report, an examination may be carried out by a representative of the medical officer of health. It is felt to be essential that this report include information about any major physical disabilities that might affect the functioning of the student and his or her participation in school activities. The results of screening tests of the student's vision and hearing are also seen as necessary to ensure that the school environment is appropriate for the needs of a given student. The provision of first aid also may be required from time to time, and may be provided on school premises if the necessary health personnel are available. The method of providing these elementary health services in the schools, and the manner of collection and storage of health records in connection with them, will be discussed when I outline the historical association between health-care providers, local public health agencies and the schools. Another factor relating to the nature of school health information that is collected has to do with the requirements of The Public Health Act, R.S.O. 1970, chapter 377, which include measures for the control of communicable disease and immunization, because the elementary and secondary schools are obviously a convenient location for the provision of public health care and immunization to school age children. Immunization information is of greater interest and concern to the public health authorities than to the school authorities.

A more recent development in Ontario relating to the learning and behaviour characteristics of children entering the school system should be mentioned. In 1971, the Ministry of Education initiated a research project in Windsor dealing with the identification of children's learning needs. Contemporaneously, boards of education elsewhere in the Province became involved in similar programmes. The experience gained from the Windsor research project culminated in a policy directive from

the Ministry of Education on December 27, 1978. The following extract is instructive:

By September, 1979, each board in the province shall approve a specific procedure to determine the child's learning needs and abilities when the child is first enrolled or at least by the time the child is beginning a program of studies immediately following kindergarten....

Each procedure shall include the following:

1. Confidential information gathering in the form of a health and/or social history with due regard given to the protection of privacy of pupil information. The form shall be part of the student's O.S.R. [Ontario Student Record] file;
2. Several opportunities for the parent and teacher to share important information about the child's background and development;
3. A multi-disciplinary approach, where required, to provide assessments by professionals outside the classroom;
4. An education assessment administered by the teacher which includes communication areas of language and number skills.

The memorandum stresses the need for the continued co-operation of local public health agencies in the provision of hearing, vision and developmental screening prior to, or upon, entry to school for the first time. It makes clear that the new programme is to supplement existing programmes by the following means:

Alerting parents to the possible need for professional attention regarding general health, hearing or vision;

monitoring and further assessment of pupil progress during the year;

planning and implementing learning experiences to aid the development of each child's education and social skills, with particular

attention to the needs of pupils who demonstrated high or low performance on the educational assessments; and

providing for a wide range of programs and services in the following years.

A subsequent memorandum, dated February 2, 1979, from Dr. Roch S. Khazen, principal program advisor in the Family Health Unit of the Program Advisory Branch of the Ministry of Health, was addressed to all medical officers of health and requested their co-operation with local education authorities in schools to carry out the early identification programme. Dr. Khazen indicated that the local public health agencies would be asked to provide, or assist in providing, the health assessment component, and the teachers would gather the health and social history on a form to be part of the student's Ontario student record file.

It can be seen that a great deal of health and related information is collected concerning students in the school system, starting at a very early age. Obviously, the medical information is being required and utilized in many areas far removed from direct patient care. The issues of confidentiality of health records that arise cannot be dealt with simply on the basis of the physician-patient or nurse-patient relationship in isolation from the information needs of non-health institutions which have been granted a legislative mandate to perform certain services in the interests of students and society at large. Before dealing with these particular issues and the positions taken by the individuals who appeared at our hearings or submitted written briefs, I turn to a description of the historical relationship between the boards of education and schools, and the health-care providers and other professionals involved in gathering and maintaining health and related information with respect to students.

The existence of school health records is an important example of the way in which health information in modern society is collected, stored and used for purposes not directly related to patient care. In fact, the existence of school health records is predicated on the concept of sharing health information as opposed to the basic requirement of confidentiality. It is not possible to discuss some of the problems of confidentiality, on the one hand, and sharing of health information related to students, on the other hand, without examining the relationship between boards of education and various health-care providers in Ontario.

In Ontario there are 43 local public health agencies established pursuant to The Public Health Act. Thirty-eight of these agencies are established as health units, most of which have a local board of health constituted and appointed as provided by the regulations, and five of the agencies are designated as health departments, in which case a local board of health for the municipality is established pursuant to the Act. Structural distinctions exist for administrative purposes, but all of these local public health agencies are charged with the responsibility of providing public health services and ensuring the carrying out of The Public Health Act and regulations and the by-laws of the municipality pertaining to public health. For each agency, a legally qualified medical practitioner is to be appointed as medical officer of health. The responsibilities of the medical officer of health are set out in section 41 of the Act:

The medical officer of health is the executive officer of the local board and, with the local board, is responsible for the carrying out of this Act and the regulations and of the public health or sanitary by-laws of the municipality.

The corresponding role for the medical officer of health of a health unit is set out in section 10 of Regulation 711 (as amended by O. Reg. 6/76, section 4) under The Public Health Act:

The medical officer of health and the associate medical officer of health of a health unit shall within its jurisdiction exercise the same powers and perform the same duties as a medical officer of health appointed under the Act.

For convenience I will refer to health units and boards of health as local public health agencies or agencies, as the context requires.

With respect to the nursing staff employed by a board of health, section 35(7) of the Act provides as follows:

Any person who is appointed under this Act as a public health nurse is subject to the direction and control of the medical officer of health for the municipality for which such nurse is appointed.

To supplement the information provided at our public hearings, we circulated a questionnaire to all of these local public health agencies. All the 40 agencies completing the questionnaire provide health services to students in the Province of Ontario enrolled in elementary and secondary schools pursuant to agreements and arrangements with the various boards of education. The other three health agencies also provide health services for their local schools. The responses to the questionnaire indicated which health professionals were providing services to schools within the jurisdiction of the local public health agency, the types of school boards served by the agency, whether or not there was a formal agreement with the school board for the provision of health services, the existing policies with respect to release of health information, whether or not the consent of the parents was required for sharing of information, the existing policies with respect to the transfer of students' health records between local public health agencies, the type of information contained in the records, the location of the storage of the health records, and whether or not the agency utilized the Computer Assisted Student Health programme (CASH), a computer-processed record system which is provided as a service by the Information Systems Division of the Ministry of Health and which I shall discuss in more detail later. See the appendix to this chapter for a summary of the questionnaire results.

Statutory authority for the agreements entered into between the various boards of education and local public health agencies is found in sections 99 and 100 of The Public Health Act:

99.(1) For the purposes of this section and section 100, "school board" means a board having charge over a public, separate, or secondary school.

(2) A school board may enter into an agreement with the local board of a municipality or health unit to provide for the medical and dental inspection and dental treatment by the local board of the pupils of the school or schools under the charge of the school board.

(3) Where an agreement is entered into by a local board under subsection 2, it has full power and authority to and, until otherwise determined by the school board, shall provide medical and dental inspection of the pupils of the schools mentioned in

the agreement in accordance with this or any other Act relating thereto and any regulations made under this or any such other Act, and shall do and perform all acts, matters and things necessary for the purpose.

(4) It is not necessary for the purposes of subsection 2 for an agreement entered into under it to provide for medical and dental inspection of the pupils of all schools in the charge of a school board or for all the schools in a municipality, but the agreement may relate to the pupils only of any one or more of such schools.

(5) Where a school board is desirous of entering into an agreement with a local board under subsection 2 and the local board refuses to enter into it, the Minister, upon the application of the school board and after hearing the representations of the local board and if satisfied that the standards established under this Act for medical and dental inspection of pupils can be provided for, may direct the local board to enter into the necessary agreement and provide for such inspection.

100.(1) Any school board may enter into an agreement with a county to provide for the employment by and at the expense of the county of public health nurses, school medical officers and dental officers in the schools under the control of the school board.

(2) Where an agreement is entered into under this section and no school medical officer is appointed by the county, the medical officer of health having jurisdiction in the place where the schools are located shall direct and control the activities of the public health nurses so employed.

(3) Where an agreement does not provide for a service in the schools of all the local municipalities forming part of the county, the county may levy the cost against

the local municipalities in which the service is provided.

The answers to the questionnaire provided by the agencies show that there is little uniformity in the practices and procedures followed in the course of providing health services to school children in order to balance the requirements of confidentiality and parental participation with the objective of providing the basic health services needed to enable the individual student to achieve his or her educational goals. The responses of the agencies were, however, characterized by a sincere concern for the interests of the student and by a recognition of the need to balance the competing interests to achieve their objectives.

The concern for the preservation of confidentiality by employees of local public health agencies, as opposed to answering the needs of the boards of education for certain information to best serve their students, is summed up in a letter received from the medical officer of health for the Grey-Owen Sound Health Unit, Dr. W. C. MacPherson:

I would agree that there is at the present time no consistent policy with respect to the release of medical information by Boards of Health across Ontario. Nor, I might add, is there a consensus within the legal profession as to the ownership of the records and whether they in fact constitute true medical records or not.

In general, I have to support the basic tenet of the confidentiality of medical records and in particular the conveyance of medical diagnoses to non-medical personnel, yet one recognizes that certain information must be shared with other disciplines in order to provide the best service for the client.

Some items such as immunization histories, should never be considered as confidential because in the event of an emergency this history may be urgently required and the nature of the information is of no consequence to other persons.

Within the school system, it may be imperative that the school know what problems

may affect the performance of the student in school, though in many cases the actual diagnosis need not be revealed. If a child has a hearing or visual problem, it may require special seating or lighting to enable the student to see or hear properly what is being offered. On the other hand, if the student is a diabetic or an epileptic, the diagnosis probably should be made known to the school authorities as a safeguard for the student. In other instances the physical limitations may be passed on to the school without a diagnosis, but giving sufficient information so that the student's problem(s) can be compensated for.

Perhaps what I am trying to say is that a great deal of common sense must be applied to the information that is transmitted to non-medical authorities. The school authorities have to have sufficient knowledge about the student's physical, mental and social economic problems to ensure that the maximum benefits can be obtained from the educational system. At the same time I think it is fairly essential that health records should be capable of being transferred between health authorities e.g. - from one Health Unit to another.

In most cases, manual student health records are maintained by public health nurses working with the medical officer of health and under his or her control by virtue of The Public Health Act, either in an office provided for the "school nurse" on school premises or board of education premises, or in the offices of the local public health agency if no office facility is available on school premises. A certain amount of health information may also be separately recorded in a special section of the pupil record. The pupil record is commonly known as the Ontario student record (OSR) in the Ministry and the profession. The content and form of this file are determined by regulations under The Education Act, 1974, and access is provided, under the Act, to school officials and to parents.

In approximately 23 cases, the local public health agency participates in the computerized record system, CASH. Periodic reports containing student health information collected by the

CASH system are returned to the individual agencies, and maintained by them.

Although historically health workers were employed by boards of education to provide services required in the schools, the development of school health services has occurred in such a way that the boards of education have gradually discontinued the practice of hiring their own health workers and have instead relied upon the services of the local public health agencies and, in particular, nurses employed by the medical officers of health.

Submissions were made to me with respect to the relationship between the Toronto Board of Education and the Toronto Department of Public Health, to which I will refer in some detail because it reflects the general development of school health services in the Province, and the pattern of the relationships between the various local public health agencies and boards of education. I also refer to the situation in other parts of Metropolitan Toronto, since it was during the course of our hearings that one of the particular problems of confidentiality and information sharing received a great deal of attention from parents, educators and health-care professionals. Many of these specific problems, and the inadequacies and vagaries of existing legislation, regulations and administrative procedures, were given much attention by the press. I am particularly indebted to those individuals from the local public health agencies and boards of education who made written and oral submissions in which they brought their concerns to my attention. They also gave me the benefit of their recommendations for the solutions to some of the problems. I have encountered some rigid responses and overreactions to practical problems with respect to school records, resulting in the creation of unnecessary impediments to some necessary exchanges of information. There have also been some examples of insensitivity to the legitimate rights and concerns of parents and guardians, though in the name of concern for the students' well-being.

Until 1917, a department of medical inspection existed within the Toronto Board of Education to provide medical services for school children, primarily for the purpose of protection from communicable diseases and monitoring participation in physical education programmes. In that year, a vote of the City electors on a referendum resulted in the transfer of the medical inspection department to the Toronto Board of Health, as it was then called, in response to provincial legislation giving local public health agencies authority to provide medical and dental inspection in schools. Subsequently, the Board of Health continued to provide the

service which had previously been provided by the medical inspection department within the school system. In consequence, medical information previously gathered and maintained by the Board of Education was, and continues to be, gathered by employees of the Department of Public Health, as it is now called in Toronto.

In 1942, the Toronto Board of Education entered into an agreement with the City's Board of Health to provide for medical and dental inspection by the Board of Health for secondary school students, pursuant to section 99 of The Public Health Act, set out above. My attention was not drawn to any written agreement with respect to the provision of such services to primary school students. Our questionnaire survey results, in fact, indicate that at least 24 of the local public health agencies have no formal written agreements with the school boards for whom they provide services, for the provision of those services.

The agreement entered into between the Board of Education for the City of Toronto and the Local Board of Health of the City of Toronto contemplates the provision of medical and dental inspection pursuant to the authority in The Public Health Act and includes the following:

2.(a) Such Medical and Dental examination and/or inspection of all or any of the said pupils as may be deemed necessary by the Medical Officer of Health for the City of Toronto from time to time.

(b) Follow-up work in the homes where necessary or desirable.

(c) First aid treatment of ill or injured pupils by the said practitioners and nurses, when available on the premises of the School Board.

The agreement requires the Board of Education to provide accommodation and furnishings for the carrying out of the agreement and the Health Board to provide medical and dental equipment and supplies and annually to appropriate such sums as are necessary for the carrying out of the agreement.

This agreement does not refer in any way to medical information, nor to the sharing of information between the Local Board of Health and the Board of Education or between health officials and school officials. This is probably typical of all

the agreements reduced to writing between local public health agencies and boards of education entered into at or about this time (1942). As I have mentioned, sensitivity with respect to the ownership, release and sharing of medical information of this type and outside the patient-doctor relationship is a fairly recent development.

Our survey, and the written and oral submissions of representatives of local public health agencies and boards of education, have indicated that, whether or not a formal agreement has existed, their relationship has consistently been based on co-operation and a belief that sharing of information between health officials and school authorities is necessary, proper and lawful. As I indicated earlier, the board of education personnel have seen health information to be an essential need of theirs to permit them to carry out their legislated obligations toward their students.

A second form of sharing of information has occurred in the form of the transfer of a student's medical record from one local public health agency to another local public health agency when that student changed his or her residence and school attendance from one municipality to another. I was told that it may be necessary and advantageous from time to time for information to be shared by local public health agency and board of education personnel with various social service agencies, including juvenile workers, Children's Aid Societies and other organizations, as part of what is known as the team approach to community health.

Our survey indicated that approximately one-half of the local public health agencies have made a practice of requiring a consent form for the release of student health information from the agency to school personnel, and approximately one-half have not had such a practice. With respect to the transferring of the student's health record outside the agency to another local public health agency, more than half the agencies have not obtained consent from the student or parent prior to such transfer. With respect to entering student information into the CASH system, the majority of the 24 agencies utilizing this system do not specifically advise parents of the nature of the system or require any particular consent for the processing of information in this form.

The sharing of student health information occurred over a long period of time without any serious challenge to the propriety of the practice or the expression of any particular concern about the effects of information-sharing on the parents' and students' rights to confidentiality. However, in 1978, a

change in policy was ordered by the City of Toronto's medical officer of health. In a letter to Mr. D. Green, director of the Board of Education, City of Toronto, dated September 11, 1978, Dr. G. W. O. Moss, medical officer of health, City of Toronto, said that he had directed his staff to discontinue the custom of sharing information concerning pupils in the absence of parental consent because, he said, of "increasing concern in society at large about release of personal information without the consent of the individual...." Dr. Moss indicated that his decision was based on the legal opinion of the City Legal Department and the response of The College of Physicians and Surgeons of Ontario to an inquiry made by him with respect to the obligations of the medical officer of health. His position is set out as follows:

Since I am advised by the City Legal Department that the records of this Department are the property of the Corporation of the City of Toronto and that I am their custodian, the release of information from them is governed by the Health Disciplines Act and Regulations which apply to me and which state that it is professional misconduct to be "giving information concerning a patient's condition or any professional services performed for a patient to any person other than the patient unless required to do so by law." I have inquired of the College of Physicians and Surgeons of Ontario whether an exception might be made of our sharing of information about pupils with school authorities. The Executive Committee of the College decided that "a Medical Officer of Health was subject to the same requirements with respect to confidentiality that applies to other physicians" and that they were "not unmindful of the administrative difficulties" but that they felt "there could be a number of arrangements made such as signing authorization for a consent to transfer such information at the time of enrollment or transfer as a means of overcoming these difficulties and that this would be desirable."

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As a result of the above, I have no alternative except to, effective immediately, direct my staff not to share information

concerning pupils with school authorities in the absence of written consent from parents or legal guardian with the exception of medical emergencies when "Good Samaritan" considerations prevail.

On October 13, 1978, the Department of Public Health requested the Legal Department of the City of Toronto to report on the following:

1. The extent to which nurses are subject to The Health Disciplines Act in relation to the release of information about the medical condition of students to principals or teachers;
2. The extent to which a principal (or teacher) can be considered to act "in loco parentis" respecting the release of medical information about students; and
3. The powers of City Council, the Local Board of Health and the Medical Officer of Health respecting the disposition of the health records of students of Toronto.

An opinion from the City of Toronto Legal Department was sent to the Local Board of Health on January 25, 1979. It concluded that although nurses are, for the purposes of Part IV of The Health Disciplines Act, 1974, S.O. 1974, chapter 47, guilty of "professional misconduct" if they fail to exercise discretion in respect of the disclosure of confidential information about a patient, under The Public Health Act they are subject to the direction and control of the medical officer of health for the municipality in which they are appointed as public health nurses. The medical officer of health, the opinion continued, is guilty of professional misconduct if he shares information concerning a patient without the patient's consent. The opinion also concluded that a principal or teacher cannot be considered to act in the place of a parent respecting the release of medical information about students in light of the provisions of The Health Disciplines Act, 1974 and The Education Act, 1974.

In a letter to the Commission dated January 22, 1979, Dr. Moss set out the following concerns of his Department:

I basically agree on the desirability and necessity for the confidentiality of health records. This is consistent with the right

of the individual to privacy. It has been a long standing practice to obtain consent to release information respecting a person's health from records in my possession. This stand originally based on professional and ethical considerations is now obligatory under Ontario Regulation 577-75 of the Health Disciplines Act, 1974 applicable to medicine. The public good appears to be amply protected by allowing exceptions under the law. Even here discretion is exercised to protect the patient by sharing information only with those whom it is felt most necessary.

The chief area of concern in my work applies to the sharing of information in the school services. It has been traditional to share such information with school officials in the mutual interest of school, health department, and child. It is not administratively insurmountable to try to obtain consent to release health information, but it is not an easy task particularly in a large jurisdiction.

It is unrealistic to expect every parent or guardian to give permission to release information on his/her child. The consequences of such lack of consent do have, however, significant impact if one considers the right of the child, and this is particularly relevant in this International Year of the Child. The education of the child can be seriously interfered with if problems of perceptual and developmental disorder are not detected by health workers, shared with educators and appropriate education programs designed for that child. Also, children with medical disorders which would put them at more than average risk in a group situation can place that child in jeopardy of accident. There is the question of liability of my staff and myself knowing that a child has a condition which would adversely influence that child's educational progress and activities and withholding that information for want of consent. Similarly, there rises a question of the handicap and

liability of school officials with respect to the responsibility for care of the child while in their custody, and their inability to plan the most appropriate education program for that child's progress.

As a result of this change in policy based on a legal opinion and the advice of The College of Physicians and Surgeons of Ontario, a large scale effort to obtain consent for the sharing of information from parents of students in Toronto was undertaken. Although the particular consent form initially brought to my attention indicated that it was to be valid throughout the child's school attendance, I was advised by representatives of the Toronto Board of Education that the intention was that the form apply for one year only. The material accompanying the consent form indicated that a parent could call the public health office with any questions, but I was told by representatives of the nursing staff of the Department of Public Health that, if a parent wished to see the health record file, the contents of which might be shared, he or she would not be permitted to do so. Consent given in those circumstances, in my opinion, cannot be called informed consent. What was involved in this issue was the propriety of the Department of Public Health's sharing of information with school personnel. Material submitted to me by the medical officer of health for the Corporation of the Borough of York included a copy of a letter from the deputy registrar of The College of Physicians and Surgeons of Ontario, Dr. H. W. Henderson, which dealt with the transfer of medical records from one medical officer of health to another:

It is the understanding of the Executive [Committee of the College of Physicians and Surgeons of Ontario] that school health records contain medical information of a confidential nature. It is also understood that the Medical Officer of Health is responsible for the maintenance of these school health records and for the confidentiality of this information. In this respect the Executive did not feel that the Medical Officer of Health was in a position that differed significantly from a physician in an occupational health centre or in private practice. It was therefore the decision of the Committee that the Medical Officer of Health was subject to the same requirements with respect to the confidentiality as applies to other physicians.

It is appreciated that the specific instance which prompted your inquiry is unusual in that a school presently in the jurisdiction of one Medical Officer of Health is being moved to a new location where it will come under the jurisdiction of a different Board of Health. This may, however, provide an opportunity for you to establish a policy of obtaining authorization for the transfer of records from one jurisdiction to another at the time of enrollment.

The concern expressed in Dr. Henderson's letter relates to the transferring of records from one medical officer of health to another, an act which, it seems to me, is analogous to the transfer of a medical file by the administrator of one hospital to another. The transfer of the medical record between hospitals is provided for in section 48(5)(b) of Regulation 729 under The Public Hospitals Act, R.S.O. 1970, chapter 378. Where a student moves from one local public health agency jurisdiction to another, a transfer of his or her health record is reasonable, and should not require an express consent of the parent or guardian. There should, however, be a right of access to the file by the parent or guardian or child. The response of The College of Physicians and Surgeons of Ontario does not seem to me to be particularly helpful. It is a very simplistic reaction to a very complex problem. The letter itself refers to the position of a physician in an occupational health centre as being similar to that of the position of the medical officer of health or a physician in a private practice. Information provided to me at the hearings and from our research, in fact, demonstrates that the position of the physician in the occupational health field is also one which is very complex and raises a variety of problems, in some respects not dissimilar to those which I am now addressing. The relationship of patient to physician found in private practice contains few of the aspects of the relationship of the individual to the physician or other health-care provider in the public health, educational or occupational setting.

Although I was informed that other medical officers of health were aware of the position taken by The College of Physicians and Surgeons of Ontario and the reaction of the Department of Public Health in the City of Toronto, in at least one case a different approach to the problem was taken. In the Borough of Scarborough, it was felt that the traditional relationship between the Department of Health and the school system and social service agencies within the Borough of Scarborough

was more important than the interpretation given by The College of Physicians and Surgeons of Ontario. Although it was felt that a consent form might be "legally" required, a decision was made to carry on with the traditional sharing of information until an appropriate form of consent could be composed.

A further dimension of the problem, pointing out the inadequacy of a legalistic response to the question of sharing of school information, was brought to my attention by representatives of the Department of Health for the Borough of North York. Health services for the schools are, to a great extent, provided in the schools by public health nurses, who are members of the Ontario College of Nurses and who are governed by the nursing part of The Health Disciplines Act, 1974, the regulation under which speaks of confidentiality in a quite different manner from that in the regulation applying to physicians. In Regulation 578/75 (Nursing) under The Health Disciplines Act, 1974, professional misconduct is defined as follows:

21. For the purposes of Part IV of the Act, "professional misconduct" means,

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(k) failure to exercise discretion in respect of the disclosure of confidential information about a patient;

A letter dated October 31, 1978, was written by Joan C. McDonald, director of the College of Nurses of Ontario, to the director of the Public Health Nursing Division of the Department of Public Health, Toronto. The opinion of the Executive Committee and counsel of the College of Nurses with respect to the position, under section 21(k), of registered nurses who do not share information with teachers about the health status or condition of children in their classes was set out in the letter:

Nurses in a public health unit are entitled to disclose information regarding children in their care to teachers provided that there is a good reason for so doing. The Regulation prohibiting disclosure of confidential patient's information (21k) is not an absolute prohibition but makes the nurse liable to penalty only if the nurse fails to exercise a reasonable discretion.

Thus, if on a subjective view of the disclosure, it can be said that the nurse had, in his or her mind, a good reason to disclose such information, the nurse would not be liable to penalty. The Regulation under The Health Disciplines Act, however, will not assist the nurse in her employment situation and her employment may be terminated if she has a direct order from the doctor in charge of that health unit not to disclose such information under any circumstances.

A great number of submissions were made to me that with respect to some medical conditions--the most commonly used example was epilepsy--in the child's best interests, it is essential for the teacher or the principal to be fully informed so that in the event of an occurrence, for example, a seizure, the school authorities would know what to do. It is apparent that guidelines are needed, not only with respect to types of information which must be shared in the interests of the child, but also with respect to the kind of information which a parent or a child may validly refuse to share.

The conflict between the right of the parent to control information generally with respect to his or her child, on the one hand, and the right of the more mature child to withhold information from school authorities or from his parents, on the other hand, are competing interests in need of reconciliation. Examples given to me were that of the 17-year-old girl who had had an abortion without the knowledge of her parents and who had confided in the public health nurse at the school. Without consulting the student, the nurse conveyed this information to her teacher and it later became apparent that the teacher had this information. However, since the student did not wish the information to be conveyed to her parents, the interests of confidentiality made for a difficult situation which could not be dealt with appropriately. In another example, a 15-year-old student gave information about his use of drugs to a public health nurse on the understanding that the information would not be given to his parents. The public health nurse shared this information with the teacher, and this information was subsequently conveyed to the parents in breach of the student's confidence.

From the anecdotal evidence provided to me in connection with the question of the existence of a right to confidentiality on the part of children, it appears that, at least for some purposes, society has drawn a line at the age of 16. Any such

decision, given the fact that children mature at different ages, must be an arbitrary decision. There are some children who at a younger age than 16 are, in fact, capable of exercising judgment with respect to their own health information. Certainly children who are recognized to have the legal capacity to seek treatment without parental consent should be entitled to the right to control their own records. For the purpose of hospital management, the age of consent to a surgical operation or medical treatment under sections 49 and 49a of Regulation 729 (as amended by O. Reg. 100/74, section 11) under The Public Hospitals Act is sixteen (and may be younger if the patient is married). The right to consent to one's own medical or surgical treatment in hospital should carry with it the right to control access to one's medical record. Although some submissions have been made to me that the age for consenting to treatment and to control of access to the medical record by a child should be lower than the age of 16, I do not think that there is sufficient evidence to justify a recommendation of a lower age.

One witness, Dr. Peter Neil Cole, director of the Family Planning Service for the Department of Health in the City of Toronto, urged upon me the desirability of selecting a younger age, in fact, 12, at which the child would have recognized his or her right to make a judgment that information should be shared. The suggestion was made that a compromise be struck. Between the ages of 12 and 16 a double consent of both parent and child should be required so that, if the parent is to be informed of health information, it would be with the permission of the child. This is not unlike one of the provisions in the bill now pending before the House of Representatives in the United States, the Federal Privacy of Medical Information Act. Section 104 of the bill provides as follows:

104.(a) Except as provided in section 103,
in the case of a patient--

- (1) who is eighteen years of age or older, all rights of the patient shall be exercised by the patient; or
- (2) who, acting alone, has the legal capacity to apply for and obtain a type of medical examination, care, or treatment and who has sought such examination, care, or treatment, the patient shall exercise all rights of a patient under this title with respect to medical information relating

to that examination, care, or treatment.

104.(b) Except as provided in subsection (a)(2), with respect to a patient who is--

(1) under fourteen years of age, all the patient's rights under this title shall be exercised through the parent or legal guardian of the parent; or

(2) fourteen, fifteen, sixteen or seventeen years of age, the right of inspection (under section 111), the right of amendment (under section 112), and the right to authorize disclosure of medical information (under section 115) of the patient may be exercised either by the patient or by the parent or legal guardian of the patient.

The provisions with respect to rights of minors in this bill were based largely on a recommendation of the American Academy of Pediatrics. I am not persuaded that this solution is appropriate for Ontario. I am partly moved by the fact that, in Canada, section 197(1)(a) of the Criminal Code, R.S.C. 1970, chapter C-34, imposes a legal duty on parents to provide necessities of life, which I believe include necessary health care, for children under the age of 16 years. I find it difficult to reconcile the existence of this duty with a measure that would deny parents the right to health information relating to these same children. In this connection, it should be pointed out that there is an inconsistency in the current state of the law in Ontario. Under section 48(5)(c)(iii) of Regulation 729 under The Public Hospitals Act, a person must be at least 18 years of age to authorize the inspection or receipt of information from his or her hospital medical record (with the hospital board's permission) whereas, under sections 49 and 49a of the same regulation, the age of consent to surgical, medical or diagnostic treatment is 16.

The Interministerial Committee on Medical Consent, in its report to the Minister of Health, the Minister of Community and Social Services and to the Attorney General, proposed the enactment of a Health Care Services Consent Act. The proposed Act fixed 16, generally, as the age of consent for treatment in or out of hospital, and provided that such treatment can be

extended to a child under 16 without parental consent if "the proposed provider of the health care service has reasonable cause to believe that the person is able to understand and appreciate the nature and consequences of the health care service and is able to understand and appreciate the consequences of giving or withholding the consent." If this proposal becomes law, my recommendation with respect to access and control of the health record of a child under 16 should be modified accordingly. The principle to be established is that a person, of any age, whose own consent is sufficient to authorize the provision of health-care services ought also to be considered competent to exercise control over his or her health record.

A submission of the Metropolitan Toronto Separate School Board pointed out two further problems. I believe that most parents do not appreciate that the student health facility is not controlled by the schools, despite the fact that forms and material are distributed to parents showing their source to be the local board of health. The usual contact with the local board of health is through a person normally referred to as the "school nurse." It is probable that in most cases when information is given to the "school nurse", particularly at the time of the initial enrolment, it is believed that the information is being given to the school or for school purposes. There may well be some occasions on which information is given to the "school nurse" in a confidential manner with the expectation that it is to be kept in confidence. The evidence leads me to suspect that this anticipation of confidentiality may be based more in an expectation that the nurse will exercise discretion in favour of confidentiality because of her professional role, rather than on the belief that the nurse's employer is, in fact, the local public health agency and not the school or the board of education.

The second problem is that of the school board which deals with several different local public health agencies, all of which have different procedures and requirements to meet their own needs, and different policies with respect to the requirement for consent to the sharing of information and the extent to which information may be made available. The solution to this problem lies in the principal recommendation in this chapter, that is, the standardization of the practices followed by all the local public health agencies.

The subjects of psychological services and their resulting records are dealt with separately, but not because there is any valid distinction to be made between the nature of health records generated in the context of mental health and testing and that of records arising out of physical health and testing.

Rather, it is because, for the most part, in Ontario, psychologists working in the school system are employed by boards of education rather than by local public health agencies. Section 23 of Regulation 704/78 made under The Education Act, 1974 provides as follows:

Psychiatrists, psychologists and other professional support staff employed by a board shall perform under the administrative supervision of the appropriate supervisory officer such duties as are determined by the board and, where such persons are performing their duties in a school, they shall be subject to the administrative authority of the principal of that school.

I was informed by the Board of Examiners in Psychology that there are approximately 1,100 psychologists registered in Ontario and that, of these, approximately 90 per cent are salaried employees. The Board estimates that there may be between 150 and 200 psychologists currently employed by school boards. The oral and written submissions made on behalf of the Board of Examiners in Psychology and the Ontario Psychological Association made it clear to me that the profession has a high degree of concern for its ethical obligations to preserve the security and confidentiality of information pertaining to its clients.

The Act giving formal legal recognition to the profession is The Psychologists Registration Act, R.S.O. 1970, chapter 372. Section 10 of Regulation 698 under this Act provides, in part, as follows:

The Board may, after a hearing, suspend or cancel a certificate of registration when it has been shown to the satisfaction of the Board that the person registered,

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(e) has been guilty of any professional misconduct or of conduct unbecoming a psychologist.

However, the Regulation does not make provision for a standard of confidentiality required by psychologists, and the Board of Examiners in Psychology, the body charged with responsibility for administering the Act, has advised its registrants that the Ethical Standards of Psychologists drafted by the American

Psychological Association have been adopted by the Ontario Psychological Association and the Canadian Psychological Association. Principle 6 of those Ethical Standards reads:

Safeguarding information about an individual that has been obtained by the psychologist in the course of his teaching, practice, or investigation is a primary obligation of the psychologist. Such information is not communicated to others unless certain important conditions are met.

In 1978, the Board of Examiners produced Standards of Professional Conduct, which contains a more detailed set of guidelines with respect to the maintenance and protection of psychological records generated by a psychological service unit. The following provisions are important in this context:

7.2 A psychologist is responsible for informing clients early in their relationship of the limits of confidentiality of psychological information within the psychological service unit and, where relevant, within the sponsoring institutional context.

7.3 A psychologist shall make available client information or records, as defined in Appendix C, only to those within the psychological service unit and to those professionals within the sponsoring institution who have a need to know in order to serve the client.

7.4 Subject to interpretation 7.3 above, a psychologist shall not release the name of a client or information regarding a client, or records as defined in Appendix C except with the informed written consent of the client or legal representative or guardian of the client except as directed by law.

Despite these statements, it was submitted to me that those psychologists who are employed by boards of education have the perception that it is not within their power to protect the privacy of their clients in the face of existing administrative practices governing teaching and non-teaching professionals involved in "special service" or "student service" departments in school systems.

The sensitivity of the type of information gathered by psychologists, and its similarity to personal health information, are summed up in this statement from the brief of the Board of Examiners in Psychology:

Unlike the bulk of the information in the Ontario School Record which is devoted to details of attendance, promotion and grades, the information collected by psychologists is highly personal, in the case of growing children may rapidly become obsolete, and is not necessarily appropriate for inclusion as part of a historical record.

As a general rule, where there is a relationship of employer and employee, if the employee has obtained information in the course of carrying out the task assigned to him or her by his or her employer, that employer has a right to the information obtained. It is not clear that there is any exception to this general statement of law that puts professional people, for example, psychiatrists and psychologists, in any different category when they are employed by a non-professional employer.

It has been made apparent to me that the physician, who is usually employed by the board of education but who may be employed by the local public health agency, is under the obligation of confidentiality set forth in the regulation relating to physicians made under The Health Disciplines Act, 1974. This statement of the obligation can be and has been used as an answer to an employer who demands information, in the particular case, student information, from the medical officer of health. I have heard evidence that the psychologists employed by boards of education, and indeed nurses, whose regulated obligation of confidentiality is not as absolute as that pertaining to physicians, find themselves in a much more compromising situation in an employment setting than do physicians. I discuss this conflict between the professional obligations of health-care professionals such as nurses and psychologists in the sections of the report dealing with occupational health. However, in this context, I repeat that there is a need for legislative intervention which makes clear the special relationship between a professional person and his or her employer, to modify some of the ordinary incidents of the employer-employee relationship in such areas as that with which I am now dealing.

The Board of Examiners in Psychology also made this submission in its brief:

...that employing institutions established with public funds to serve the public interest should be required, in formulating administrative regulations, to consider the obligation of the professional employee to protect the privacy of the public they serve. The Board is of the view that the argument of being in "loco parentis" should not be used to obtain blanket permission for sharing of all information among employees of the school board. Provision should be made for psychologists, or other professionals, to exercise discretion.

When a psychological assessment is made by a psychologist employed by a board of education, a consent from a parent of the child is required. However, once that consent is given, the information obtained becomes available within the educational system. The concerns of the psychologists seem to be directed to subsequent control. Ownership of materials generated by the psychologist in connection with the preparation of such an assessment, where information is generated for school purposes, probably resides in the board of education. Control over the files of the psychologist employee of the board may not be within his or her power. The distinction that has developed between psychological information, on the one hand, and information about physical health, on the other, both types of information being equally essential to a full understanding of the child, his educational needs and his well-being, is arbitrary and impossible to defend.

Recommendations:

104. *That, where a local public health agency enters into an agreement with a board of education to provide inspection or other health services for students of that board of education, the agreement include the following provisions:*

(a) the categories of information collected and maintained in the health record shall be disclosed by the collecting agency on request;

'b) a parent of a student, or the student, if he or she is 16 years

of age or more, has a right to inspect health information with respect to that student maintained by the local medical officer of health;

(c) an authorization by a parent, or the student, if he or she is 16 years of age or more, shall be required for the release of health information concerning a student to any person not directly involved in the health care of the student in the collecting agency;

(d) the medical officer of health may disclose health information the agency maintains about a student without the authorization described in section (c):

(i) if, in his opinion based on clinical judgment, the information is necessary to alleviate an emergency affecting the health or safety of a student; or

(ii) to the medical officer of health of another local public health agency to within the jurisdiction of which the student has moved, provided that the parent, or the student, if he or she is 16 years of age or more, has been notified of the intended disclosure before it occurs in order that he or she may have the option to prohibit the disclosure;

(e) any consent to release of information required with respect to health information shall state the period of time during which the consent is valid, the nature of the information to be released, the individuals or authorities to

whom the information is to be released, and that there shall be no further disclosure by the receiving individual or authority without the consent of the parent, or of the student, if he or she is 16 years of age or more; and

(f) the medical officer of health shall be responsible for carrying out procedures necessary to ensure that any health information maintained with respect to a student is timely, accurate and relevant to any health or related requirements of the student for the purposes of his education, or in compliance with public health programmes.

105. That provisions (a) to (f) of the preceding recommendation apply to the manner in which information concerning a student generated by a psychologist employed by a board of education is collected, maintained and released, and for this purpose, the terms, "department of psychological services" and "psychologist", respectively, shall be substituted for the terms, "local public health agency" and "medical officer of health", in the preceding recommendation.

My recommendations with respect to the sharing of information requiring an authorization of parents, except in an emergency situation, is based in part on the evidence given at our hearings that only a small percentage of the students actually have serious medical conditions which have been made known to the local public health agency. I am not satisfied that the problems described to me could not be resolved either by the obtaining of consent in the case of that minority of students for the release of medical information, or by the medical officer of health undertaking the practice, now carried on in some locations, of indicating restrictions on a student's activity without providing a medical diagnosis of his or her condition for general purposes.

Information with respect to immunization and sight and hearing screening are by far the most common types of information relating to students gathered and maintained by the local public health agencies. It is clear that information about immunization is of primary concern to the agencies in dealing with communicable disease in the community, but it is not so clear that this type of information is relevant to the programmes of the boards of education. Accordingly, I cannot see that a case has been made out for the routine sharing of such information with board of education employees. With respect to programmes for screening sight and hearing, it is reasonable that information concerning such programmes be provided to parents at the time their children are enrolled, and the parents' co-operation in permitting this information to be made available to the school authorities should be requested at that time. If a subsequent problem develops concerning the child's sight or hearing, it would again be proper that the parent be informed of the condition, even if he or she has previously authorized information to be provided to the school authorities.

Before 1969, in schools served by local public health agencies, public health nurses gathered health information about students, particularly with respect to immunization, and maintained it in non-standardized manual files. In 1969, a committee was set up, composed of representatives of schools, local public health agencies and systems analysis experts provided by the Ministry of Health, to produce a computerized programme for the standardized recording of student health information. The system that was established and that has been operational since about 1972 is known as Computer Assisted Student Health, or CASH, and performs two functions. It brings to the attention of the public health nurse any action required with respect to a given child, such as vision testing or immunization. It maintains a record for every student in the system. A further product of the system, perceived as a benefit by the Ministry of Health, is the provision of statistical information and reports on the health status and requirements of children in the school system. In addition to providing a standard method of recording and storing individual health information by school and local public health agency, the system is designed to retrieve specific information common to the agencies, allow for utilization of such information to plan and evaluate school health programmes, and reduce clerical time on the part of nursing personnel. Since the information is identifiable and the system is computerized and has provision for collecting the social insurance number and Ontario Health Insurance Plan number, it has the potential for future linkage with other health information systems.

There are currently 25 local public health agencies which participate in the CASH system. Four of those participating units require that parents be asked to sign a consent form before information concerning their children is entered into the CASH system. The remainder of the agencies do not require that consent be requested or obtained.

The CASH system contains approximately 800,000 student records, and is designed to record health data along with the following identifying information:

Health unit number; school number; social insurance number; birth order; surname, given name; OHIP number; sex; birth-date; birth weight; whether English is spoken.

There is also collected a variety of information with respect to immunization received or not to be received by the child, including a position with regard to the parents' consent or objection to immunization, which is necessary since immunization is not compulsory in Ontario. The School Health Records Master File created by the system also provides general "flagging" information with respect to the health status of the child, including the following:

Anemia, cardiac, cerebral palsy, cystic fibrosis, diabetes, epilepsy, hemophilia, leukemia, respiratory, rheumatic fever, tuberculosis, T.B. contact, dental, nutritional, gross motor co-ordination, fine motor co-ordination, mental health, social and emotional adjustment, vision, colour vision, speech, hearing, developmental screening test, urinalysis, medication, Physical Education limitation.

Allergy: feathers, eggs, neomycin, asthma, eczema, hay fever, stings, animals, food, allergy - general.

Genito-urinary: kidney, urinary tract, enuresis, undescended testicle, GU - general.

Musculo-skeletal: bone deformities, anomalies.

Other: brain damage, mental retardation, minimal brain dysfunction, ulcers, bowel disorders, repeated headaches, repeated stomach aches, other.

Glasses, vision test date, hearing test date, BCG, TB test date and result.

In the Borough of Scarborough where between 75,000 and 80,000 students are included in the CASH system used by the Department of Health approximately 95 per cent of the student records contain only immunization information and the results of vision and hearing screening. In other words, only about 5 per cent of the students in the system have recognized health problems that are shown by the system. Only those students with known health problems have an independent student health file set up alongside the student record which is part of the CASH system. I mention this figure because of the perceived problem of obtaining consents for the sharing of information. One health department, not on the CASH system, that of the City of North York, has indicated that the percentage of children with known health problems in its municipality is not more than 10 per cent. On the available evidence, that estimate is valid for the school population generally. There is good reason to conclude that the actual number of children with recognized health problems in the schools is approximately 5 to 10 per cent of the general school population. This figure is relevant when weighing the argument that obtaining specific consents to the release of health information poses serious administrative problems to public health authorities.

In oral and written submissions made to me, both support for and objection to the system were expressed. For example, Dr. Marguerite Archibald, medical officer of health for North York, said that she had some concern about the validity of the information in the system. "Validity" in this context relates to the fact that the source of information on the computer print-out is not noted, so that no one referring to the information can know whether the source was a nurse, physician, parent or even teacher in some cases. As I have said, this concern was not directed to the fact that the system was computerized, but only to the source of the information about the health status of a child. Some of the questions about control over the dissemination of that information and the period of time the information remains on file are particularly appropriate to a large, computerized system, and are the type of questions dealt with in greater detail in the chapter relating to computers and health information.

On the other hand, the following information as to the positive benefits of a computerized system was set out in an example provided in a submission to us by Dr. Lucy M. C. Duncan, director and medical officer of health of the Lambton Health Unit.

The immunization records of our school pupils were used by us in 1976 to cope with

an emergency situation following the diagnosis of diphtheria in a child [living at a certain location, and attending a certain school]. Manual checking of microfiche school health records for the contacts of the case was started while we awaited the arrival from the Ministry of consent forms for inadequately immunized students. The Health Unit's work was very much easier because of these computerized records.

Parents rely on the records we keep--it is easy for us to provide a parent with an immunization record--records for those immunized in physicians' offices or hospital emergency departments are not so easily obtained by the parent.

A computerized system of recording immunizations of adults and children would be helpful and would prevent over-immunization--with possible allergic reactions--to Tetanus toxoid.

Two examples of parental objection to aspects of this system were given in the same submission:

Another parent insisted that we delete his children's names from the Computer Assisted School Health Program.

A third objection was directed at our request for the social security number, which is used on CASH to identify the student.

As I mentioned earlier, the actual computer processing of information for the local public health agency on the system is performed at the offices of the Ministry of Health. For a description of general data processing procedures in the Ministry of Health offices at Leaside, see the chapters on computerized health information and OHIP. Source documents are sent from the agencies directly to the Ministry. The information is entered onto tape by an external service bureau and source documents are returned along with the processed tape to the Ministry offices. The output of the system is in the form of microfiche which is produced every three months and printed reports which come out monthly. Each health unit receives that portion of the output that refers to students in its area. The

tapes in the system comprising the master file for the system are password protected and, like other sensitive Ministry of Health computer files, have been password protected since November, 1977, when allegations in the press that sensitive files in the Ministry of Health were being improperly run and examined by Ministry of Health employees working with the computer resulted in a general tightening of security.

I have described the CASH system in some detail because it is a computerized information system containing information with respect to a very large percentage of school children in Ontario. Although I was not provided with information about any other computerized systems that may be in use in any of the agencies not on CASH, the recommendations with respect to security, integrity, accuracy and timeliness of information in a computerized system apply as much to any other system as they do to the CASH system. The benefits of having student health information in such a uniform and accessible form have been pointed out, including the advantages to epidemiologists, public health planners, financial planners and researchers, and the ability of the system to bring special needs of certain children to the attention of health-care providers. However, the very fact that such a record can be conveniently examined and may well be the most timely and accurate form of record available with respect to a student supports the desirability of access to that record on the part of the parent. The immunization status of a child is surely of as much concern to a parent as to the local public health agency and, accordingly, should be available to that parent.

It has been made apparent to me that it is essential that health authorities and educators have available information pertaining to the health of students when it is relevant to the educational requirements of that student and, on occasion, to the health needs of the community. However, it is also essential that the right of students to privacy and the rights of parents to privacy and to share in information that may be generated with respect to their school children must be protected and respected. For the purposes of my recommendations, health information should be understood as including all personal information relating to a student's physical and mental health and development and the results of any tests or treatment given to the student.

Recommendation:

106. *That the restrictions and controls to be exercised in connection with student health information apply*

whether the information is obtained by a physician or any other health-care professional having a direct relationship with students or their parents, and whether or not the professional person is employed by a local public health agency, board of education or other authority. Where the health-care professional involved is an employee of any such authority, the requirements set out in this chapter, as well as the ethical requirements of any professional regulatory body of which that person is a member, should take precedence over any right of access the employer may have, exercises, or attempts to exercise in connection with health information. However, no health-care professional who releases information in accordance with the criteria I have mentioned should, by virtue of that release, be considered or held to be in breach of any rule relating to professional misconduct established by a professional regulatory body.

Existing definitions of professional misconduct formulated by the governing bodies of the health-care providers should be amended so as to make it clear that there may be circumstances in which that health-care provider, because of a special relationship or special circumstances, may reveal information in his or her possession without being in breach of his or her professional ethics. For example, the recommendation that a medical officer of health be permitted to transfer information to another medical officer of health requires a recognition in the rules governing disclosure of confidential information that a medical officer of health acts in a different capacity from that of an ordinary physician in his or her relationship with patients.

APPENDIX

PUBLIC HEALTH UNITS: SURVEY OF HEALTH RECORDS

	Yes	Yes (with qualifications)	No	No (with qualifications)
1. Indicate which of the following health professionals employed by your board of health provide service to schools: - Nurse - Doctor - Psychologist - Speech Therapist - Psychiatrist - Social Worker - Dentist - Other (please specify)	40 24 3 5 4 3 31 35			
2. Which of the following types of school boards are served by your health board? - Separate - Public - Junior High/Senior Public - Secondary - Other (please specify)	40 40 29 37 26			
3. Is there a formal agreement or contract between the board of health and the school board for the provision of health services?	12	2	23	2
4. Do you have any policy regarding the release of student medical information from the school nurse to a teacher or other board of education employee without parental consent?	8	5	19	6
5a. At enrolment time, are parents requested to sign a consent form for the release of student medical information from nurse to teacher?	15	4	17	4
b. What percentage of parents sign the consent form? 70% 80-85% 90% 95% 99% 99%+ 100%	1 2 1 2 2 4 6			

PUBLIC HEALTH UNITS: SURVEY OF HEALTH RECORDS

	Yes	Yes (with qualifications)	No	No (with qualifications)
6. At enrolment time, are parents requested to sign a consent form for the release of student medical information from the family physician to the nurse?	1		28	9
7. Please provide some examples of actual situations in which the teacher has required student health information from the nurse.	39			
8. When the student transfers to another school outside the boundary of the particular health board, is the student's medical record transferred without the consent of the parents?	12	10	11	6
9. What type of student health data is contained in the nurse's health file? - Past medical history - Current medical file - Parent's medical history - Medication - Other (please specify)	29 31 5 33 17	4 6 3 4 3	1 8	 1 2
10. Are student's health records stored at: - School unit, department or board - Health unit, department or board - Other (please specify)	18 23 7	7 8		
THE FOLLOWING QUESTIONS APPLY ONLY TO THOSE HEALTH UNITS WHICH UTILIZE THE CASH (Computer Assisted Student Health) SYSTEM.				
11. How many years has the health unit been using the CASH system? - less than 1 year - 1 to 2 years - 2 to 3 years - more than 3 years	2 22			
12. Are parents requested to sign a consent form prior to student health information being entered into the CASH system?	4		16	3

Employee Health Information

In addition to the use made of them in administering health care itself, health records are commonly used in the field of employment. Medical and health information may be obtained from:

- (i) pre-employment medical examinations to determine fitness for work or suitability for a particular job;
- (ii) claims made by employees pursuant to sickness and accident benefits provided by the employer or insurance programmes;
- (iii) medical certificates for short term sickness benefits;
- (iv) claims made under The Workmen's Compensation Act, R.S.O. 1970, chapter 505;
- (v) medical care or treatment of an employee during the course of employment;
- (vi) the monitoring of employees for occupational diseases under either mandatory or voluntary programmes; and
- (vii) drug and alcohol programmes formed, usually with the co-operation of the employees' union, to assist employees who have addiction problems.

The purpose of an employer in keeping medical records, particularly a large industrial employer, was stated by Dr. Rodney May (formerly an assistant deputy minister in the Ministry of Labour) in an article published in Occupational Health, January/February, 1968, at page 31, as follows:

- (a) to provide a record of basic information used in Job Placement,
- (b) to assist in establishing Physical Standards,
- (c) to record treatments carried out on Company Premises,
- (d) to note reasons (diagnoses) for sickness absence,

- (e) to record the need (and reasons for) light or modified duties,
- (f) to record firsthand details of injury which may later result in a Claim for Compensation,
- (g) to collect data for use in Epidemiological Studies,
- (h) to provide material for statistical evaluation of Health Programmes,
- (i) to facilitate co-ordinated exercises with Personnel Management Department,
- (j) to assist in matters relating to employee control,
- (k) to provide information for use when reviewing all aspects of Safety, Health and Welfare.

Not all employers have all of these programmes, but in fact many of them do, particularly the large industrial ones such as General Motors of Canada and the Ford Motor Company of Canada, to name two on behalf of whom evidence was given at our investigative hearings.

The concerns of the employee in connection with the accumulation of all this information about him or her are:

- (i) that the information is not used by management to make decisions about him or her which will place his or her job in jeopardy or cause him or her to be placed in a position with lower pay and security, and
- (ii) that the information will not be given to third parties without his or her consent.

The accumulation of this potentially vast amount of information about an employee presents the employer with administrative problems of how to store the information, where to store it, who shall have access to it within the organization, and whether the employee is entitled to see the information. How all this information is handled usually depends in large part on the size of the employer involved.

During the course of our investigative hearings in Windsor, it became apparent that not everyone agreed whether certain information was employment information or health information. To avoid confusion in the context of this discussion of the employment relationship, the term "health information" will be used. The term includes any information that relates to the health of employees, any treatments received, the names of the persons or institutions providing the treatments, any periods of absence from work due to ill-health and the reasons for these absences. This list is not exhaustive but indicates the type of information intended to be protected.

From the files taken from the offices of private investigators, we discovered that health information was obtained from employers, without the knowledge or authorization of the employees to whom the information related, on 408 occasions. On 15 of these occasions, the information was supplied by occupational health nurses. In most cases the information was supplied because of a pretext used by the investigator requesting the information. The person supplying the data thought that he or she was helping the employee by giving out the information.

John Todd of the firm Jolie & Todd Investigations, which centered its activities in the County of Essex, testified that he knew that the manufacturing companies within that area possessed a substantial body of health information relating to their employees. Sources at certain employers were regularly used by either Mr. Todd, his partner George Jolie or their employee, Charles Richard Stickley, like them, a licensed private investigator.

Although the Ford Motor Company of Canada Ltd. has a policy that no medical information is to be given out concerning an employee without the written authority of the employee, an analysis of the files that we obtained shows that, in fact, health information was obtained from that source on five occasions. General Motors of Canada Ltd. has a policy that no information about either employment or health can be given out without the written consent of the employee concerned, but we discovered eight occasions on which unauthorized health information had been released.

These employers were not the only ones from whom confidential medical information was obtained but they became the centre of attention during the investigative hearings because they were the firms likely to be contacted on a more or less regular basis by reason of the large number of persons employed by them. It was stated in testimony that it was, in fact, usually easier to obtain information from the smaller employers, probably because

in these firms all information on any one employee is kept in one place. Nor is there any suggestion that the obtaining of health information from employers was restricted to the Windsor area. A study of the files taken shows that employers across Ontario were contacted. There was even a suggestion made by Kieran Patrick McCarthy of Quest Investigation Ltd. that some employers were sympathetic to the position of an investigator investigating a claim relating to an employee, because of the possibility that he or she was overstating his or her case. The employers, according to Mr. McCarthy, were therefore prepared to disclose all health information in their possession. Whatever justification there may be for this impression, I am confident that, like most generalizations, it is not accurate.

Employees, of course, are unlikely to learn of access to health information held by the employer by third parties acting in an interest contrary to that of the employee. But even if an employee were aware that health information had been released without consent, authority is lacking which would support a successful claim for legal redress against the employer or the person releasing the information. It is nevertheless arguable, as a matter of general principle and public policy, that an employer must preserve confidentiality with respect to medical information about employees. There are at least two legal bases upon which an action to enforce an obligation on the part of the employer to preserve confidentiality might be founded, at least by analogy. The employer-employee relationship is reciprocal in nature; since the employee is under an obligation (which continues even after termination of his employment), not to use to his employer's disadvantage confidential information gained during the course of his other employment (Batt, The Law of Master and Servant (5th ed., 1967, at pages 212-213 and 238-241), a similar duty is "presumably equally imposed on the master in his servant's favour" (ibid., at page 241). However, this author goes on to say that if the servant has left the employ of his master and the disclosures by the (former) master are not defamatory, "it is not easy to see any action which the servant could successfully bring" (ibid.).

The employee's obligation to respect the confidentiality of information obtained during the period of employment appears to be contractual in nature, although equitable concepts of "good faith" and "constructive trusts" also receive mention in the authorities. As the action which the employer brings against his former employee is an action for breach of contract (more specifically, breach of the express or implied covenant to maintain the confidentiality of confidential information obtained during the course of employment), the reciprocal right of the employee should be enforceable in a similar manner. However,

proof of damages would be difficult, if not impossible, as would proof of the circumstances necessary to obtain an interlocutory injunction. Therefore, even if relief is theoretically available through civil action, which is certainly not clear, the expense of bringing an action would be prohibitive, particularly in view of the chances of obtaining an effective remedy.

There is another potential legal basis for the employer's duty to maintain the confidentiality of employees' health records. This second approach proceeds by analogy to the principles applicable to information received by an employer as a result of inquiries made to his employee's (or prospective employee's) employer or former employer. The textbook referred to above states the view that the employer "would have no right to publish (such information), or make any use of it other than the purpose for which it was obtained, such other uses constituting a breach of faith." (Batt, supra, at page 237). In a footnote the author notes that "how far (the employer) has a right to disclose (such information) to other persons has not, to the writer's knowledge, ever been decided."

Legislative action is required expressly to prohibit an employer from revealing any health information concerning any present or former employee to any third party (unless otherwise required by statute) without the consent of the employee or his or her agent. But such a prohibition would be meaningless unless it were accompanied by a sanction in the form of a fine or a right on the part of the employee to obtain damages in a fixed but significant amount against the employer, without the need to show pecuniary loss. In my view both sanctions should be enacted to emphasize the importance of the employee's interest. The legislative action which I recommend in this chapter can be brought about either by amendments to The Employment Standards Act, 1974, S.O. 1974, chapter 112, or by the enactment of a statute relating to employee health information, whichever is thought to be more appropriate.

Recommendation:

107. *That legislation be enacted to make it an offence for an employer to reveal any health information concerning any present or former employee to a third party (unless otherwise required by law) without the consent of the employee.*

The methods used for storage and administration of health information by an employer depend on the size and the type of activity of the enterprise. Where the employer is a large industrial one, such as the automobile manufacturers, the employer is more likely to have a physician or physicians employed full-time. Employees of these employers probably have group sickness and accident insurance coverage provided by the employer and, depending on the type of enterprise, claims under The Workmen's Compensation Act will be more common than for a smaller non-industrial enterprise. Health information may be held at several places within the company or even within each plant operated by the company:

- (i) The medical department will have results of pre-employment medicals, periodic examinations, testing for occupational hazards, and any visits made to the medical department during the period of employment;
- (ii) there may be various sections within the personnel department with health information, such as:
 - (a) a payroll or finance section, which may have the certificates obtained from a physician for short term illness,
 - (b) a workmen's compensation section with medical information relating to these claims,
 - (c) an insurance section, which processes claims under the sickness and accident group insurance. Some employers, such as The Chrysler Motor Company of Canada and the Windsor Separate School Board, actually process the claim on behalf of the insurance company involved and pay the employee directly, using an insurance company cheque. In the case of other employers, the insurance section ensures that the claim is properly completed before forwarding it to the insurance company for processing. The insurance section, however, retains a copy of the claim form which includes the physician's diagnosis of the illness or injury.

It frequently happens that one department or section, such as workmen's compensation section, needs to obtain information from another department or section, for example, to determine whether the injury for which a workmen's compensation claim is being made is related to a pre-existing condition or previous injury, or to determine whether the claim should properly be made as a workmen's compensation claim rather than as a sickness and accident benefits claim. Information is given to other

sections of the personnel department on a "need to know" basis. Resort may be had to the file on the claimant in the insurance or payroll sections to obtain the necessary information. There is a degree of trust. The evidence is that if the information is held by the medical department, the personnel there usually discuss the matter with the person requiring the information but will not release the file or allow it out of the medical department.

Smaller employers or those whose activities do not generate as many medical problems may have either a physician employed on a part-time basis only or a nurse or nurses on a full-time basis to maintain the medical department. In cases in which there is a physician employed part-time but no nurses to assist him or her, results of medical assessments are usually forwarded to the company and are processed by the personnel clerks or first aid attendants who may not have an adequate appreciation of the confidential nature of the information. Sickness and accident insurance claims and forms from physicians to cover short term absences are usually held in the personnel department, together with other employment information about the employee. Where no medical department exists, the personnel department often holds all health information relating to an employee, including pre-employment medical examinations, reasons for absences due to ill-health, and other health information, in the employee's personnel file.

This description of the maintenance of health information within industry is sufficient to demonstrate many of the dangers inherent in the systems now used, particularly in smaller enterprises. Wherever health information is kept along with employment information in one place, accessible to all persons working in that place as well as those at the management level, the employee has reason to fear that his or her health problems may be used to make employment decisions about him or her, such as that involved in removing the employee to a lower paying job or even in terminating the employment.

Recommendations:

108. *That all health information be stored separately from other employee information.*
109. *That all persons handling employee health information be given written guidelines relating to the confidentiality of the information. These guidelines, which should be*

established by the Ministry of Labour in consultation with the Ministry of Health, should deal with the collection, retention, storage, security, access, disclosure and destruction of identifiable employee health information held by employers.

110. That all health information be kept in cabinets which should be locked and accessible only to those persons directly involved in administering that information.
111. That for an internal transfer of information within the employer, from one department or one section to another, the consent of the employee be obtained.
112. That an employee have a right of access to all of his or her health information held by an employer, including a right to request that corrections be made, if necessary, or a notation of his or her objection.
113. That the results of laboratory testing performed on employees or applicants for employment be sent either to the health personnel (if any) or to the physician requesting the tests. Non-health personnel should not be permitted to open the reports of the test results.

One subject of concern has been the practice of employers sending health information about employees outside Ontario for storage (often on computers), usually but not always to the head office of the corporation. Employees care because they have no control over, or knowledge of, the use made of this information. One justification for the practice given by an employer was the need to obtain the information for epidemiological research to be done on behalf of the employer by either in-house physicians or outside consultants. While research for the purpose of reducing the incident of occupational disease is a laudable undertaking, it is possible to take measures to reduce the magnitude of the breaches of privacy involved.

The sending of health information out of the Province of Ontario should be prohibited unless all identifying information is removed. If the use of the material is for epidemiological research, a code could be devised, provided that the key to the code is retained in Ontario. In this way, if an employee is moved from one section of the plant to another or to a different plant where a different manufacturing process or chemical is used, this fact could then be noted for epidemiological purposes, without the need to know the name of the employee. This involves little additional administrative work for an employer.

Recommendations:

- 114. That the sending of employee health information outside the Province of Ontario be prohibited unless all identifying information is removed.*
- 115. That where the reason for storing the information outside Ontario is that it be used for epidemiological research in respect of the employer's operations, a code be devised to enable an employee to be identified, but the key to the code must be retained in Ontario.*

In Ontario, 110 physicians are employed full-time by private industry in providing occupational health services, according to the estimate in the brief submitted by the Occupational Health Section of the Ontario Medical Association. The Association also estimates that perhaps another 450 companies are served by physicians on a part-time basis. There are approximately 1,200 occupational health nurses in Ontario of whom 75 per cent work in occupational health settings without the support of a physician, according to the brief submitted by the Ontario Occupational Health Nurses Association. In addition, other health professionals are often employed, such as industrial hygienists and psychologists, as well as first aid attendants and those assisting in the recording and storage of data.

Health professionals employed by others are subject to the same requirements of confidentiality as are their fellow professionals. These health professionals face a conflict between their duty with respect to the requirements of confidentiality of patient information and their duty to obey the instructions of their employers. There is substantial evidence that often

pressure is exerted on health professionals to disclose information to the employer. This is a special problem for the occupational health nurse who is not perceived by our society to have as high a status as the physician and, on the available evidence, is therefore more likely to be subject to pressure from the employer to reveal confidential information. This pressure was referred to by occupational health nurses individually as well as by their Association. It is shown in the testimony of Doreen Stuart, personnel manager of Dare Foods Ltd., who stated at our hearings that she "never expected Dr. Wilson (the company physician) to divulge anything in the way of diagnosis" and that she "would not question Dr. Wilson" in relation to his categorization of an employee or potential employee as suitable for certain types of work. On the other hand, Mrs. Stuart stated that she would only accept the decision of an occupational nurse in whom she had confidence:

MR. COMMISSIONER: What I am having difficulty with is that you seem to accept that kind of solution where the doctor is involved. Where at a moment of crisis, because of the nature of the problem, the doctor isn't available but the nurse has the information, and there is no question about the validity of the information, I take it that you would not accept her professional judgment?

MRS. STUART: I would accept the professional judgment of a nurse that I had confidence in, yes.

MR. STROSBERG: Do I understand then what you are saying is if you had confidence in the judgment of the nurse then you would treat her or accord her judgment the same respect that you would a doctor in the situation that has been outlined?

MRS. STUART: I think that would be fair to say.

MR. STROSBERG: But if you didn't, then you feel that you are obliged to go further and obtain particulars of the health information?

MRS. STUART: Right.

MR. STROSBURG: You reserve to yourself the right to make the judgment as to whether or not you have confidence in the nurse?

MRS. STUART: I would think I would have to. She reports to me.

Mrs. Stuart appeared at our hearings inquiring into an incident that had occurred at the Dare Foods Ltd. plant in Kitchener. This plant manufactures cookies and biscuits and employs approximately 350 to 400 people. The plant has a medical department which is situated on the second floor of the building. Dr. L. R. S. Wilson has been the plant physician for about 20 years, working two hours a week at the plant and giving advice by telephone when necessary. One nurse was hired on a full-time basis to work in the medical department. Mrs. Joan Voll, who had been the nurse since February 16, 1976, was expected to report to Dr. Wilson with regard to medical matters. Mrs. Voll said that she had been instructed by Dr. Wilson that if Mrs. Stuart, the personnel manager, requested information about an employee, Mrs. Voll was only to give her "interpretative information" unless Mrs. Stuart had an authorization from the employee. Although Dr. Wilson denied giving Mrs. Voll instructions which divided information into "medical" and "interpretative", he did expect her to use her judgment and discretion with respect to the information she gave Mrs. Stuart about an employee. There were no written guidelines to help her solve any dilemma she might have to face. One of Mrs. Voll's responsibilities was the taking of a medical history from a job applicant prior to Dr. Wilson's physical examination. Originally the consent form on the pre-employment medical questionnaire authorized the release of medical information to the medical department but this was later changed to authorize the release of the information to Dare Foods Ltd. Mrs. Stuart believed that this authorization not only entitled her, as personnel manager, to have access to the information obtained on the pre-examination questionnaire and examination but to any health information that came into being about the employee during the period of the employment. For example, one piece of medical information resulting from the pre-employment medical examination which Mrs. Stuart felt she was entitled to have was whether a female employee was pregnant at the time of the examination. It was considered to be uneconomical for the company to train a pregnant person for work in the plant, even if the pregnancy was at an early stage.

Although Mrs. Stuart was aware that Dr. Wilson wanted the medical records to stay in the medical centre, she did, on occasion, require Mrs. Voll to attend at her (Mrs. Stuart's)

office with a health or medical file, as can be seen from the following answers she gave to questions put to her by Mr. Strosberg:

Q. Did you know that Doctor Wilson's rule was that the medical records were to stay in the medical centre?

A. I knew that the rule was they were to be kept under lock and key in the medical centre. I didn't know it was against his wishes for a nurse to have a file in her hand and walk outside the office.

Q. And take it down to your office?

A. I didn't interpret it that way.

Q. Did you know that Mrs. Voll interpreted it that way?

A. No, I really didn't.

Q. She said that she told you on several occasions, as I understood her evidence, that she was not to remove the medical records from the medical centre.

A. I didn't understand her to say remove them physically.

Q. What did you understand her to say?

A. My understanding was that those files were to be kept under lock and key in the medical centre at all times. I felt it was perfectly all right for the nurse to have a file in her hand as long as that nurse was in command of that file, as long as she didn't give it to anybody else.

Q. Did you, when this matter was raised by Mrs. Voll, talk to Dr. Wilson?

A. No, I didn't.

This information is given by way of background to the incident which I was investigating because of its relevance to the problems of confidentiality of health information. In March

or April of 1977, a worker at the plant advised Mrs. Voll that he had a skin rash which his doctor had provisionally diagnosed as being a highly contagious skin disease that was capable of being passed through food. The worker did not handle food but worked on a machine that monitored the flow of dough to shape the product. The product then moved from that machine into the ovens, where it was baked. Mrs. Voll contacted the worker's physician who offered to speak to Dr. Wilson. Because Dr. Wilson was unavailable, Mrs. Voll spoke to the associate medical officer of health for Kitchener-Waterloo who advised her that the worker should be sent home immediately. Mrs. Voll advised Mrs. Stuart of this. Mrs. Stuart was concerned that if the man were sent home immediately the assembly line would have to be shut down. If there could be a delay of about one-half hour, another person could be brought in to replace him.

Although aware that the decision that the worker should be sent home was that of the associate medical officer of health and not that of Mrs. Voll, and although aware that a contagious skin disease was involved, Mrs. Stuart asked Mrs. Voll to telephone the associate medical officer of health again to see whether the departure could be postponed long enough for a replacement to be found. When advised that the departure should be immediate, Mrs. Stuart demanded and obtained the provisional diagnosis from Mrs. Voll. Mrs. Voll felt sufficiently pressured to give the diagnosis, although she thought that she was wrong in doing so. When given the diagnosis, Mrs. Stuart ordered that the man be sent home immediately. She frankly admitted that her desire to know the diagnosis was to enable her to make a decision whether it was necessary for the man to go home immediately, and not because she wanted to determine whether it was necessary to shut down the plant or take some other action. She did not take any action that might cause the product already made to be recalled and destroyed. Once Mrs. Stuart had been told that the associate medical officer of health had directed that the man be sent home immediately, she should have arranged for him to go home without further questioning.

Mr. Peter Radley, the director of manufacturing at the Dare Foods Ltd. plant in Kitchener, stated that, after the worker left the plant, a meeting was held between himself, the plant manager and Mrs. Stuart, to discuss what should be done about the product. At all times it was felt that Mrs. Voll was at fault for not divulging the diagnosis. Mrs. Stuart, however, did not indicate that she knew the diagnosis. Mrs. Stuart said "...there was such a fuss over getting the diagnosis that I made sure I kept it to myself. Now maybe I made an error in judgment there."

Regulation 972/75 (as amended by O. Reg. 926/79, section 1), concerning food premises under The Public Health Act, R.S.O. 1970, chapter 377, provides:

46.(1) Subject to subsection 2, every operator or employee who handles or comes in contact with food or with any utensil used in the preparation, processing or service of food shall,

.

(f) be free from and not a carrier of any disease that may be spread through the medium of food; and

.

47. No person who,

(a) has a skin disease;

.

shall perform work that brings him in contact by any means with food in food premises unless he has applied for and been exempted from the provisions of this section by the medical officer of health.

48.(2) Where an operator knows or has reason to believe that an employee is in contravention of clause (e) or (f) of section 46, or section 47, he shall notify the medical officer of health.

It is not only nurses who give information to the employer, either voluntarily or under pressure. Some physicians give information to the employer without obtaining the consent of the employee. This may not be the result of pressure applied to them but because of a perceived duty to protect the interest of the employer. Examples are shown in such arbitration decisions as Re Douglas Aircraft Co. of Canada Ltd. and United Automobile Workers, Local 1967 (1973), 2 L.A.C. (2d) 147, and Re Northern Telecom Ltd. and United Automobile Workers, Local 1837 (1977), 16 L.A.C. (2d) 50, in both of which cases the physician passed on to the employer information about the existence of

psychiatric illnesses in employees which had not been disclosed at the pre-employment medical examinations.

Another example of the type of conflict that can arise, but from a different perspective, is illustrated in a story in the New York Times, Sunday, February 3, 1980. The story concerned genetic testing that was being conducted by some chemical companies to determine if certain workers had a pre-disposition towards certain diseases:

At Dow Chemical Company, a company doctor found evidence of undue chromosome breakage among workers exposed to benzene, a widely used chemical and a known carcinogen.

"We wanted them to tell the workers what we had found, reduce the levels of benzene to which workers were exposed and inform the appropriate Government agencies and the rest of the petrochemical industry," Dr. Dante J. Picciano, a Dow geneticist, said. Dow refused, saying Dr. Picciano's data were hard to evaluate and that it would not have been responsible to alarm workers by citing data that might ultimately prove to be inaccurate. Dr. Picciano left Dow.

Physicians who appeared before me at the hearings, and who were employed on a full-time basis as industrial physicians, were very much aware of their responsibilities regarding the confidentiality of health information of the employees. The only part-time physician who appeared was Dr. Wilson. Dr. Wilson was aware of his duty of confidentiality and had instructed Mrs. Voll not to release health information to the employer but, when first asked, told me that he did not consider the employees he examined on behalf of Dare Foods Ltd. to be in a patient-physician relationship with him, in which case the duty of confidentiality imposed by section 26, paragraph 21 of the regulation concerning medicine under The Health Disciplines Act, 1974, S.O. 1974, chapter 47, would not be applicable. He later conceded that the employees were in a patient-physician relationship with him but the important point is that, with all his experience in occupational medicine, he did not realize this at the outset. I am not at all certain that most part-time industrial physicians recognize their relationship with the company's employees to be one of physician-patient.

In the case of professionals who are employed by boards of education, the problem is further complicated by section 23 of

Regulation 704/78 under The Education Act, 1974, S.O. 1974, chapter 109:

Psychiatrists, psychologists and other professional support staff employed by a board shall perform under the administrative supervision of the appropriate supervisory officer such duties as are determined by the Board, and, where such persons are performing their duties in a school, they shall be subject to the administrative authority of the principal of that school.

Hugh M. Kelly, counsel for the Metropolitan Toronto Separate School Board, in his appearance at our policy hearings, submitted that this provision was limited to either the administrative authority of the supervisory officer or, when in a school, the administrative authority of the principal, but that the provision did not affect the professional responsibility of the person. I am not sure that all school boards act in accordance with Mr. Kelly's sensible interpretation.

Strictly speaking, in the normal employer-employee relationship, what is known to the employee should also be known to the employer. The problem that arises when the employees are professional persons who have an obligation of confidentiality, whether that obligation arises under a regulation under The Health Disciplines Act, 1974, or whether the obligation arises because of a code of ethics to which they subscribe, is whether the employer can reasonably expect the employee to violate that confidentiality obligation. The issue is not one of ownership of records, but of access and control. No professional employee should be placed in a position of having to violate professional ethics in order to fulfil his or her obligation to an employer. It is questionable whether an employer has the right to require an employee with professional qualifications to violate his or her duty of confidentiality.

It was observed by Mr. Justice Pigeon, in passing, in his reasons for judgment in Attorney General of Quebec and Keable v. Attorney General of Canada et al., [1979] 1 S.C.R. 218, at page 250, that:

...an employee's duty of obedience towards his employer does not mean that the latter has any power to compel his employee to act in breach of a duty of confidentiality. The medical director of a hospital cannot release a doctor from his obligation of

confidentiality towards his patient, only the latter may release him from his duty.

Although it may be argued that, as a matter of law, this statement is not an authoritative pronouncement on the common law relating to the employer-employee relationship, it is highly desirable that legislation be enacted to the same effect as the statement, that is, to make it clear that the professional employee's duty of confidentiality transcends his or her duty or obedience to the employer's orders.

Recommendation:

116. *That legislation be enacted to make it clear that a professional employee's duty of confidentiality transcends his or her duty to obey an employer's instructions, where those instructions require the employee to reveal information held in confidence.*

The obligation of confidentiality is not confined to the health professional employee of an employer. It relates to the function of an employee rather than to his or her status. I believe that the duty to treat employees' health information confidentially rests with any person whose duty to the employer is to provide a health-related service to his, her or its employees. This includes such persons as first aid attendants. A similar duty exists for any person who is responsible for the storage and handling of employees' health information obtained or collected by those employees providing a health-related service to other employees.

A view often expressed is that ownership of records entitles the owner to control over and access to them. Some employers pay lip service to the concept of confidentiality but insist on retaining a key to the cabinets in which the health information is kept, "in case of fire". Other employers refuse to allow nurses to keep health information in locked cabinets. Complaints have been made by nurses working in public hospitals that administrators of those hospitals consider the records which must be kept under section 67 of Regulation 729 under The Public Hospitals Act, R.S.O. 1970, chapter 378, of tests and examinations done of the staff members, to be available to them without restrictions. Hospital administrators should treat the records relating to employees in the same manner as any other employer. A distinction should be made between the role of a hospital as a provider of health services and its role as

employer of the many persons through whom it provides the services.

Psychologists employed in Ontario face a problem not shared by members of those professions governed by The Health Disciplines Act, 1974, and the regulations under that Act, such as medicine and nursing, in that the requirements of confidentiality are not enacted as regulations but by a code of ethics published by their governing body, the Ontario Board of Examiners in Psychology. The confidentiality provisions enunciated by the Board of Examiners are set out in some detail in the chapter on school health records. As I indicate in that chapter, the fact that the ethical obligations to preserve the security and confidentiality of psychologists' records are not set out in regulations does not mean that there is less concern among psychologists to respect confidentiality.

As I also indicate in that chapter, conflict arises for the psychologists employed by a board of education over storage and control of background data, test results, and notes used in making assessments of children within the school system. Some school boards assert ownership over the psychologists' files, which includes access to and control over the use of the information in the file. One incident that occurred recently illustrates this dilemma.

In 1977, the Lakehead Board of Education decided to discontinue its psychology department. The chief psychologist, Dr. A. Krichev, was concerned about the confidentiality of the files generated by members of that department once all the psychologists had left the employment of the school board. Dr. Krichev proposed that all materials written for use by the schools be sent to the schools, that is, the formal reports of the psychologists and the materials prepared by the teachers and principals for the use of the psychology department, but that all other materials be considered to be his property as the registered psychologist in charge. This was not acceptable to the school board. An arrangement was made by Dr. Krichev with one of the employees of the school board that the files would be placed in the custody of a registered psychologist, Dr. A. H. Shapiro, pending a consideration of the question whether the Regional Children's Centre would be a more appropriate custodian of the files until the issue of the board's entitlement was decided. The Regional Children's Centre refused to accept the responsibility and the files remained in the care and custody of Dr. Shapiro. The board of education wrote to Dr. Shapiro demanding the return of the files. Negotiations ensued but no settlement could be reached. Legal proceedings were commenced by the school board asserting ownership and the return of the

files. On an application by the school board for the return of the files for its interim use until the hearing of the action, a consent order was made that the files and the filing cabinets be delivered to the custody of the court and that the school board could have access to them. An application was made on behalf of the defendants for the employee with whom Dr. Krichev had made the arrangement for the files to be left with Dr. Shapiro, to attend for an examination. That order was refused by Judge P. S. Fitzgerald who said in his reasons for judgment:

In my view the evidence sought to be so adduced would be unlikely to persuade the court that the body which furnished the materials for the making of the records and their storage and paid their employees to create them does not have substantial grounds to claim ownership therein and to have custody thereof pending final disposition in an action where all property discovery may be had and the issue of title finally determined.

(The Lakehead Board of Education v. Shapiro et al., March 1, 1978.)

The matter was resolved by a consent order that the files and cabinets be returned to the school board and that the tests, protocols and personal notations be removed from the files. This meant that the issue of ownership of the individual items in those files was never decided on the merits, although the statement of Judge Fitzgerald, in refusing the application for an examination of the employee, recognizes the problem that would be faced by the defendants.

Recommendations:

117. *That the responsibility for the storage and control of health information about employees be declared to be that of the health professionals employed by the employer, or, if there are none employed, a physician designated by the employer.*
118. *That the employer not be allowed access to health information about an employee without the consent of the employee concerned.*

In what should be rare occurrences, the duty of confidentiality may have to yield to some other transcending interest. The health professional also owes a duty, to the employees as a group and to the public, to ensure the safety of the group or of the public. I say this duty should arise only rarely because in most instances when the need to disclose confidential information does occur the health professional should advise the employee about the need for disclosure. The best evidence we have is that only very rarely is consent refused in these circumstances. An example of such a situation was mentioned by an occupational health nurse at a recent conference of the Ontario Occupational Health Nurses Association. A worker at her plant was passed by the company physician as being "fit to work". His pre-employment medical examination revealed that he was an epileptic whose condition was controlled by medication. After a year, the man was promoted to a machine job. The nurse later ascertained, after the man had had a dizzy spell while beside the machine, that he had not taken his medication. He has since suffered two seizures while operating the machine because of his failure to take his medication consistently. He will not give his consent to the disclosure of his condition to management because of a fear of losing his machine job and enhanced rate of pay. The nurse advised management that she considered the worker should not be on the machine. She was asked to obtain a report from the physician who has written to her, but not to management, that the man has shown immaturity in taking his medication. This is an example of a worker who is endangering only himself, although, no doubt, in so doing he puts his employer's workmen's compensation levy in potential jeopardy. But in other circumstances there could be a serious risk to the safety of other workers or even to the public at large, where, for example, the worker is engaged in the manufacture of such potentially dangerous products as automobiles which, by reason of inattention, could turn out to be unsafe.

Recommendation:

119. *That where, in the opinion of a health professional, disclosure of confidential information is necessary because of a clear danger to the employee, fellow employees, or to the product resulting in a danger to the public and*

(a) the employee concerned consistently refuses to give consent, and

(b) a second opinion is obtained from the employee's personal physician when the concern is for the health of the employee, or from the medical officer of health when the risk is to the public or to fellow employees,

the health professional may make the disclosure to the proper person at management level after giving notice in writing to the employee, which notice shall indicate the confidential information intended to be disclosed.

Many employers require that applicants for jobs have pre-employment medical examinations to ascertain if they are fit for the positions applied for or to determine fitness to work generally. These examinations may be done by a physician employed, either on a full-time or a part-time basis, by the employer or by physicians in private practice who forward the results of the examinations to the employers. Pre-medical examinations may be very detailed and may include questions relating not only to present state of health but also to childhood illness and to health histories of family members in some instances. Many of these questions are designed not only to determine fitness for present employment but to detect susceptibility to hazards that may exist in the plant or workplace. An employer will be less willing to employ someone who already has a hearing loss or whose family shows a history of deafness when noise is an important factor in the job. This is based, in part, on the fact that an employer's contribution under The Workmen's Compensation Act is related to the number of claims made by its employees. Another factor that weighs with an employer is an employee's susceptibility or perceived susceptibility to certain diseases which may or may not be occupationally caused.

An example of a pre-employment questionnaire and medical examination is shown below. This is used by a large employer in the manufacturing industry for both its pre-employment examinations and annual medical examinations.

Pre-employment _____	Plant Location _____
First Company Medical _____	Date _____
Name _____	Employee Number _____
Home Telephone _____	S.I.N. Number _____
Date of Birth _____	
Place of Birth _____	

OHIP Number _____

Marital Status _____

In case of emergency; contact _____

Family Doctor _____ Reason for last consultation: _____

Address _____

Telephone Number _____

Do you wear a Medic Alert Bracelet?

Yes _____

Why? _____

No _____

EMPLOYMENT HISTORY

(Including Any Military Experience)

Previous Employer	Type of Work	From	To	Exposures	Protective Equipment Worn
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[Company name] Employment

Location - Unit

The following information will be held by the Medical Centre and is for the use of the Medical Officer only:

HOBBIES

Do you or did you enjoy or use any of the following:

	<u>Yes</u>	<u>No</u>	<u>Don't Understand</u>
1. Regularly listen to live or recorded music	_____	_____	_____
2. Snowmobiles	_____	_____	_____
3. Chain Saws	_____	_____	_____
4. Other types of Power Tools	_____	_____	_____

5. Firearms _____
6. Tractor Driving _____
7. Automobile Racing _____
8. Under Water Diving _____
9. Working with Paints,
Solvents, Paint Strippers _____
10. Flying either privately
or publically _____
11. Do you smoke? Yes _____ How much? _____
No _____ How long ago did you
quit? _____
12. Do you consume alcohol? Yes _____ How much _____
No _____
How long ago did you
quit? _____
13. Do you take Medication on a regular basis?
Yes _____ No _____
if so, Type _____ Dose _____

PAST HEALTH & FUNCTIONAL ENQUIRY

- | DO YOU HAVE OR HAVE YOU HAD: | <u>Yes</u> | <u>No</u> | <u>Don't Understand</u> |
|--|------------|-----------|-------------------------|
| 1. any allergies | _____ | _____ | _____ |
| 2. headaches regularly | _____ | _____ | _____ |
| 3. backaches regularly | _____ | _____ | _____ |
| 4. a backache now | _____ | _____ | _____ |
| 5. a headache now | _____ | _____ | _____ |
| 6. any problems with
your spine | _____ | _____ | _____ |
| 7. any cardiovascular pro-
blems (including heart
murmurs, high or low blood
pressure, angina, heart
attack) | _____ | _____ | _____ |

- | | | | | |
|-----|--|-------|-------|-------|
| 8. | tuberculosis | _____ | _____ | _____ |
| 9. | venereal disease | _____ | _____ | _____ |
| 10. | diabetes | _____ | _____ | _____ |
| 11. | stomach trouble | _____ | _____ | _____ |
| 12. | ulcers | _____ | _____ | _____ |
| 13. | asthma | _____ | _____ | _____ |
| 14. | chest problems | _____ | _____ | _____ |
| 15. | kidney or bladder trouble | _____ | _____ | _____ |
| 16. | muscular disease | _____ | _____ | _____ |
| 17. | emotional problems | _____ | _____ | _____ |
| 18. | permanent defect caused
by birth, illness, disease
or injury | _____ | _____ | _____ |
| 19. | any tumours | _____ | _____ | _____ |
| 20. | cancer | _____ | _____ | _____ |
| 21. | any medical problems
which are now affect or
which may in the future
affect the satisfactory
performance of your job | _____ | _____ | _____ |

DO YOU HAVE:

Female:

- | | | | | |
|-----|------------------------------------|-------|-------|-------|
| 22. | are you pregnant now | _____ | _____ | _____ |
| 23. | have you any menstrual
problems | _____ | _____ | _____ |
| 24. | are you taking birth
control | _____ | _____ | _____ |

HAVE YOU EVER BEEN OR HAVE YOU EVER HAD:

- | | <u>Yes</u> | <u>No</u> | <u>Don't Understand</u> |
|--|------------|-----------|-------------------------|
| 1. any operations | ___ | ___ | ___ |
| (a) how many _____ | | | |
| (b) what were they for <u>and</u> when (be specific) | | | |
| 1. _____ | 3. | | |
| 2. _____ | 4. | | |
| (c) what hospitals were you confined in (please give in order corresponding to the numbers in (b)) | | | |
| 1. _____ | 3. | | |
| 2. _____ | 4. | | |
| 2. been admitted to hospital for other than surgical reasons | ___ | ___ | ___ |
| 3. dismissed from a job because of illness | ___ | ___ | ___ |
| (a) number of times <u>and</u> when | | | |
| (b) who was employer <u>each</u> time | | | |
| 4. payments from a Workmen's Compensation Board | ___ | ___ | ___ |
| (a) number of times <u>and</u> when | | | |
| (b) <u>length</u> of time benefits were received each time that they were received | | | |

DO YOU:

- | | | | |
|--|-----|-----|-----|
| 5. refused insurance on medical grounds | ___ | ___ | ___ |
| (a) number of times <u>and</u> when | | | |
| (b) insurers who refused you | | | |
| 6. x-rayed for any reason | ___ | ___ | ___ |
| (a) when was last time | | | |
| (b) reason x-ray taken | | | |
| (c) where taken | | | |
| 7. seizure, fit convulsion or fainting spell | ___ | ___ | ___ |

Yes No Don't Understand

- (a) how many times have
you had them
- (b) did you seek medical
advice
- (c) what were you told
- (d) when was the last time
that you had a seizure,
fit, convulsion or a
dizzy spell

CURRENT CARE

ARE YOU AT THE PRESENT TIME UNDER THE CARE OF A DOCTOR,
OSTEOPATH, CHIROPRACTOR OR OTHER HEALTH PRACTITIONER?

YES _____ NO _____
if yes, Name _____
Address _____
Telephone No. _____

IMMUNIZATION:

HAVE YOU EVER BEEN IMMUNIZED AGAINST:

	<u>Date of</u> <u>Primary</u>	<u>Date of Last</u> <u>Booster</u>
Diphtheria		
Polio		
Tetanus		
Pertussis		
Small Pox		
Red Measles		
German Measles		
Influenza		
Other		

FAMILY HISTORY:

	<u>Age if</u> <u>Living</u>	<u>Date at</u> <u>Death</u>	<u>Present Health Status</u> <u>or Cause of Death</u>
Father			
Mother			
Brothers or			
Sisters			
Children			

HAS ANYONE IN YOUR FAMILY SUFFERED FROM:

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Diabetes			Asthma		
Hypertension			Allergies		
Heart Disease			Lung Disease		
Kidney Disease			Hearing Problems		
Cancer			Other		
Epilepsy					
Tuberculosis					

I declare that the foregoing facts are true to the best of my knowledge.

Signature: _____

Witness: _____

Date: _____

PHYSICAL EXAMINATION

NAME: _____

S.I.N. # _____

Ht. _____ cm.

BP sitting left arm _____ mm hg.

Wt. _____ kg.

Pulse or HR _____ /min.

Vision: Normal _____

Hearing: Normal _____

Abnormal _____

Abnormal _____

Date: _____

Result: _____

Chest x-ray

Back x-ray

Urinalysis, blood tests, other tests recorded on lab summary.

Normal Abnormal Not Examined

1. Head and Neck

Bony contour

Range of movement

Masses palpable

Organomegaly

2. Eyes

Pupils

Conjunctiva

Lids

Fundi

		<u>Normal</u>	<u>Abnormal</u>	<u>Not examined</u>
3.	Ears			
	Pinna	_____	_____	_____
	Drums Rt.	_____	_____	_____
	Left	_____	_____	_____
	Canals	_____	_____	_____
	Cerumen	_____	_____	_____
4.	Nose			
	Septum	_____	_____	_____
	Other	_____	_____	_____
5.	Throat			
	Tonsils	_____	_____	_____
	Teeth	_____	_____	_____
	Other	_____	_____	_____
6.	Chest			
	Bony Thorax	_____	_____	_____
	Lung fields	_____	_____	_____
	- expansion	_____	_____	_____
	- breath sounds	_____	_____	_____
	- adventitious sources	_____	_____	_____
7.	CVS			
	Heart sounds	_____	_____	_____
	Murmurs	_____	_____	_____
	Peripheral pulses	_____	_____	_____
	Other	_____	_____	_____
8.	Abdomen			
	Palp masses	_____	_____	_____
	Organomegaly	_____	_____	_____
	Hernia - inguinal Rt.	_____	_____	_____
	Left	_____	_____	_____
	Other	_____	_____	_____
	Rectal	_____	_____	_____
	Genitalia	_____	_____	_____

9. Back & Ext.

inspection	_____	_____	_____
palpation	_____	_____	_____
movement	_____	_____	_____
power	_____	_____	_____
other	_____	_____	_____

10. CNS

Romberg	_____	_____	_____
co-ordination	_____	_____	_____
tremors	_____	_____	_____
sensation	_____	_____	_____
visual fields	_____	_____	_____
other	_____	_____	_____

11. Skin

_____	_____	_____
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12. Details of abnormalities:

Recommendations: _____

In addition to answering the questionnaire and undergoing the testing, an applicant for a job with that employer is also required to undergo hearing tests.

Other examples of questions asked on various employers' application forms relating to health information are:

Have you ever been hospitalized in the last ten years?

Date of last health examination. Reason for examination. Results of examination.

Have you ever undertaken treatment for mental or emotional problems?

Have you any defects in hearing, in vision, in speech?

Do you suffer from any permanent illness or disability? If yes, what is the nature of illness or disability.

Have you received Workmen's Compensation payments as a result of being employed in a

position similar to the position being applied for?

Have you had a major illness in the past 5 years?

Do you drink alcohol? Have you ever had a problem with alcohol? Do you wear glasses?

What serious illnesses or accidents did you have as a child?

State any medical restrictions, Doctor's name, date last examined.

What surgical operations or serious illnesses have you had?

What lost time Workmen's Compensation cases have you had?

Have you ever filed for Workmen's Compensation?

Number of days missed in the last 2 years due to illness.

Have you ever had hay fever, asthma, ulcers, hernia, allergies, etc.?

List any serious illnesses, operations, accidents or nervous disorders you may have had with the approximate date.

Have you any physical defects or other limitations? Explain fully.

What has been your most serious illness?

Frequently on these forms the applicant is required to sign a consent which may authorize "any hospital or physician who has treated me to furnish any and all medical information to (the employer)" [emphasis added]. The most extreme form of authorization of this type that I have seen is the following:

Do you also agree that for the consideration of being considered for employment and of being employed by this company, that this statement or any photo copy of this

statement containing your signature shall serve as notice, with your permission, without liability, to any licensed doctor, hospital, clinic, or sanitarium to furnish upon this company's request, any and all medical information to this company that such doctor, hospital, etc. may possess relative to your personal health, and/or medical history; and such information may be used by the company, without liability, in any manner deemed necessary relative to the continuance of your employment with this company, and any refusal or reasonable delay by such a doctor, hospital, clinic, etc. in furnishing such requested information shall be deemed just cause for immediate and continued suspensions of your employment (without wages and benefits) including discharge, if deemed necessary by the company.

Of course, a consent obtained in this way is not a genuine consent. Persons in need of employment will sign such a consent, either because they are unaware of the effect of the document or because, if the choice is between signing the consent and not obtaining a job, they choose to sign the form. The consent form is far reaching when it is addressed to "any hospital and physicians" or any "licensed doctor, hospital, clinic or sanitarium". Nor are the consent forms quoted limited in time; information could be obtained relating to childhood illnesses and diseases. We have had evidence of applicants for employment being rejected because of the employers' access to pre-employment health information that did not accurately reflect the applicants' true condition at the time of the application for employment.

A matter brought to my attention by the Ontario Human Rights Commission was that of an applicant who alleged that he had been discharged after an employment officer of the employer discovered that he had previously received workmen's compensation benefits; the person was dismissed, even though declared fit to work by the Workmen's Compensation Board.

Under The Occupational Health and Safety Act, 1978, S.O. 1978, chapter 83, proclaimed on October 1, 1979, pre-employment medical examinations may become mandatory in certain industries or at places of employment where certain metals or chemicals in manufacturing processes are used. The regulations for mines and mining plants, O. Reg. 660/79, already provide for this in

sections 187, 274, and 277, as does section 250 of O. Reg. 659/79 concerning persons who work in compressed air. Certain other occupations have statutory requirements of physical fitness or freedom from tuberculosis or other infectious diseases. These are generally occupations in institutions or organizations established by the government to deal with the needs of the sick, the elderly, the disabled and children who are in need. Such occupational groups as ambulance drivers, hospital employees, day nursery workers, and teachers, are regulated in this way. The requirement, however, is usually stated to be the production of a certificate that "the person is physically fit to undertake duties..."

The advantages to the employer of receiving the complete pre-employment medical form are indicated in this submission made by the Canadian Textiles Institute, the only employer group to make such a submission. I believe, however, that many employers would endorse the views expressed.

For many years, it has been a general practice in this industry to require job applicants, to whom a mill seriously considers making an offer of employment, to have a physical examination by a qualified medical practitioner licensed to practise in the province concerned. The company pays the full cost of this examination. The applicant authorizes the physician to send a copy of his report to the company for its confidential use in evaluating his (or her) general health record and physical qualifications to perform the duties and responsibilities of the employment concerned.

The ever increasing costs of health insurance plans and the training of new and inexperienced employees to perform intricate hand and machine operations with safety and dexterity also makes their good health an essential requirement.

The pre-employment medical examination also provides distinct advantages to the prospective employee. It makes reasonably sure that he (or she) has no previously undiscovered physical impairment such as loss of hearing, defective eyesight, impaired sense of smell or unknown inherent

allergies which could trigger a physical condition that might cause the new employee serious health problems in the future.

Many employees, however, would disagree with the views expressed in that brief. They do not feel that it is necessary for the employer to have all the information that is now required. Where there is a possibility of an occupational hazard or disease inherent in the work environment most employees would accede to the need for full physical examinations for their own protection and safety. They fear, however, that at present employers make or may make use of the information for other purposes.

Some physicians have also written to me to express their concern with the scope of these examinations and with what is considered to be unnecessary information. One physician informed me that some forms ask for results of Wasserman tests, pap smears and details of past pregnancies. I am persuaded that the amount of detailed information required is often of little relevance to the important question, which is whether the person is fit for the employment being offered.

In the case of Womeldorf et al. v. Gleason et al., United States District Court for the District of Maryland, April 4, 1978, the plaintiff had applied for a job as a social worker with the Montgomery County, Maryland, welfare department. She was denied employment when she refused to answer questions such as "Have you ever had any vaginal discharge?", and "Do you have fear of heights?", and refused to give a blanket consent to disclosure of her medical records on the county's pre-employment questionnaire. After bringing an action in a federal court, the plaintiff succeeded in negotiating the removal of the intrusive questions and blanket consent clause. One disputed question that was allowed by the court to remain on the pre-employment questionnaire was:

Are you presently, or have you been in the last 5 years, on a continuing basis, under a physician's care for any condition not previously mentioned on this form?

The plaintiff had contended that this question was "mere surplusage" when viewed with other questions such as:

Do you have any physical or medical condition which would in any way affect or restrict performance of the job for which you are applying?

The court disagreed with this contention:

Finally, this court must disagree with plaintiff's argument that the disputed question is merely cumulative and adds nothing to an otherwise fully comprehensive questionnaire. As noted in defendant's memorandum, the question which asks about any physical or mental condition which might affect job performance is subjective in nature. As a result, an applicant might, in good faith, fail to reveal a medical condition which he or she did not believe would affect job performance, when in the opinion of the county such condition might well be considered material to the hiring decision. An example of such a condition would be a minor medical problem which requires regular treatment during working hours. Surely the county could properly consider such a factor which would affect an applicant's availability for service while at the same time a completely honest applicant might not feel that such a minor medical problem would affect job performance and hence would not mention the condition in response to the subjective performance question. With the disputed question included in the form the possibility of such relevant information being excluded is greatly lessened.

Other indications of this tendency in the United States to limit the type of questions asked of job applicants is that a very large employer, IBM, no longer asks whether an applicant has ever been treated for a psychiatric illness and another, Bank of America, which changed its employment application form in 1976, now asks, in relation to health, only, "Do you have any condition, illness or disability either temporary or permanent which may affect your ability to do the work in the position applied for?"

Employers do have a legitimate right to know if a worker is capable of performing the task assigned without incurring frequent absences. This means striking a balance between the two interests. Pre-employment medical examinations should relate only to the question of the fitness of the applicant to perform satisfactorily in the position which the applicant has applied for and should not be an inquiry into the complete

medical history of the applicant, unless such an examination is part of a programme, either mandatory by statute or regulation or voluntary, for the purposes of monitoring occupational hazards and disease; questions relating to history of family illnesses should be limited in this way; requests for records and details of past illnesses should be limited to fixed time periods.

I can see no objection to the examination being conducted by a physician employed by the company, either on a full-time or part-time basis, provided that the results of the examination are not given to the employer who should be advised only of the individual's "fitness to work". The results of the examination should be kept by the physician, either within the medical department if there is one or, if not, in the physician's office, and should not be made part of the employee's personnel file. Where the employer has no health personnel on staff, but has specific health requirements for employment because of the type of enterprise carried on, as illustrated by the Canadian Textiles Institute, the employer should be required to forward to the physician making the examination a job description to make him or her aware of the relevant health requirements. The results of the examination and any tests done by the physician should remain with the physician whose advice to the employer should be limited as I have suggested. If the applicant is fit for employment but with limitations on his or her activities because of a health problem, the physician should advise the employer of the limitation without disclosing the need for the limitation.

Recommendations:

- 120. That the only information which can be given to a prospective employer after a pre-employment medical examination be whether the applicant is fit for the employment.*
- 121. That if an applicant is fit with certain limitations, these limitations must be stated without disclosing the reasons for the limitations, for example, "unable to lift heavy loads or loads above X pounds" or "limited bending".*
- 122. That where a medical department staffed by health personnel is maintained by the employer, the results of*

the examination be kept in the medical department but not be available to the employer except as recommended in the two preceding recommendations.

- 123. That where the pre-employment examination is done by a physician not employed by the employer, the employer provide that physician with a job description so that he or she may be aware of the fitness requirements of the position and that a copy of the recommendation be given to the applicant.*
- 124. That the applicant be entitled to a copy of the examining physician's record of examination if he or she so requests.*
- 125. That where the recommendation is that an applicant is not fit for the position an explanation for the recommendation, indicating the reasons, be given to the applicant by the physician making the examination, if so requested.*

Some employers require their employees to undergo an annual or other periodic physical examination. Employees suspected of having health problems affecting their ability to work at a satisfactory level are sometimes required to submit to a medical examination by the employer. If the result of an examination of that kind shows that the employee's job should be changed, the employer should be so informed in a manner that is in keeping with the recommendations relating to pre-employment medical examinations.

Recommendation:

- 126. That whenever an employee is required to undergo a periodic medical examination or a medical examination because of a suspected health problem, and as a result an opinion is given that the employee's job should be changed, recommendations 120 to 125 apply.*

Although it is not provided for by The Employment Standards Act, 1974, many employees in Ontario have the right to be paid at their normal rate of pay or at a reduced rate for a specified number of sick days. This right is contained in most collective agreements; where it is not covered by a collective agreement or there is no collective agreement, many employers extend this benefit to their employees as a matter of custom.

One example is the following sickness plan which is found in the agreement between the Ontario Public Service Employees Union and Management Board of Cabinet respecting employee benefits for the period of October 1, 1977, to September 30, 1978:

SHORT TERM SICKNESS PLAN

Article 13.1 Effective the 1st day of April 1, 1978, an employee who is unable to attend to his duties due to sickness or injury is entitled to leave-of-absence with pay as follows:

- (i) with regular salary for the first six (6) working days of absence,
- (ii) with 75% of regular salary for an additional 124 working days of absence in each calendar year.

13.2 An employee is not entitled to leave-of-absence with pay under 13.1 of this Article until he has completed 20 consecutive days of employment.

13.3 Where an employee is on a sick leave-of-absence which commences in one calendar year and continues into the following calendar year he is not entitled to leave-of-absence with pay under 13.1 of this Article for more than 130 working days in the 2 years until he has returned to work for 20 consecutive working days.

13.4 An employee who has used leave-of-absence with pay for 130 working days in a calendar year under 13.1 of this Article must complete 20 consecutive working days before he is entitled to further leave under 13.1 in the next calendar year.

13.5 The pay of an employee under this Article is subject to deductions for insurance coverage and pension contributions that would be made from regular pay. The employer paid portion of all payments and subsidies will continue to be made.

USE OF ACCUMULATED CREDITS

13.6 An employee on leave-of-absence under 13.1(ii) of this Article may, at his option, have one quarter (1/4) of a day deducted from his accumulated credits (attendance, vacation or over-time credits) for each such day of absence and receive regular pay.

13.7 An employee who is absent from his duties due to sickness or injury beyond the total number of days provided for in 13.1 of this Article shall have his accumulated attendance credits reduced by a number of days equal to such absence and he shall receive regular pay for that period.

13.8 13.7 does not apply to an employee when he qualifies for and elects to receive under the Long Term Income Protection Plan.

13.9 Where, for reasons of health, an employee is frequently absent or unable to perform his duties, the employer may require him to submit to a medical

examination at the expense of the employer.

13.10 After five (5) days' absence caused by sickness, no leave with pay shall be allowed unless a certificate of a legally qualified medical practitioner is forwarded to the deputy minister of the Ministry, certifying that the employee is unable to attend to his official duties. Notwithstanding this provision, where it is suspected that there may be an abuse of sick leave, the deputy minister or his designee may require an employee to submit a medical certificate for a period of absence of less than five (5) days.

IMPLEMENTATION OF THE SHORT TERM SICKNESS PLAN

13.11 An employee appointed prior to March 1st, 1978, will be covered by the Short Term Sickness Plan as of April 1st, 1978.

13.12 Employees appointed to the Civil Service prior to March 1, 1978, who are absent due to sickness or injury on April 1, 1978, will be covered by the Short Term Sickness Plan.

13.13 Notwithstanding Article 13.12 employees receiving L.T.I.P. benefits as of April 1, 1978, must complete 20 consecutive working days of employment to qualify for benefits under the Short Term Sickness Plan.

13.14 Employees appointed on or after March 1, 1978, must complete 20 consecutive working days of employment to qualify for benefits

under the Short Term Sickness Plan.

13.15 An employee shall have the attendance credits earned since October 1, 1977, added to his total of accumulated credits.

13.16 If an employee has an attendance credit overdraft as of March 31, 1978, such overdraft will be forgiven.

The requirement of the number of days of absence permitted before a medical certificate is necessary will, of course, vary depending on the agreement; in some instances the period may be two days, three days or all absences. How often this term of the collective agreement is enforced will depend, to some extent, on the past absentee record of the individual concerned. Robert Rideout, union relations manager at the Oakville office of the Ford Motor Company of Canada, who appeared at our hearings in Windsor, when asked whether employees were always required to bring a medical certificate from a physician after an absence of two or three days as required by the collective agreement answered:

It varies. I think it would be misleading you if I said no. If I could take the two extremes, it might make the answer more easy to give. If you had an employee whose record with us was very good, and let's say he was long service and missed little time, and he returned to work after a brief, or even a lengthy absence, and offered an explanation of his absence, that likely would suffice. On the other hand, we have employees who are poor attenders, and who have set a questionable record of their attendance with us, and in those cases, it would not be unusual to ask the employee to substantiate his absence with some authorization from a medical practitioner.

I suspect that this attitude is not unusual.

Many employees and some physicians feel that the extent of the information required on the medical certificate needed to be produced exceeds beyond what is necessary for the employer to determine whether the employee was indeed sick. They believe

that by requiring a diagnosis of the illness, the employer is invading the confidentiality of the employee's health information and that it is only necessary for the employer to know that the employee was sick and needed to stay away from work. The employers, on the other hand, contend that it is often essential for them to have the information to enable them to ensure that unnecessary sick leave is not being taken, or that the employee has actually recovered from an illness and will not need to take further absences. Another reason sometimes given for requiring the information is to help the employee and to avoid exposing him or her to additional problems.

In this context I refer to an article in the journal "Accident Prevention" of May, 1978, entitled "Absenteeism--One Company's Answer" based on an address by Trevor Stevenson at a conference of the Canadian Association of Rehabilitation Personnel. In that article the following passage appears:

On November 1, 1975 we introduced the nurse visitation program as an integral part of our overall absentee control program. This involves the use of outside registered nurses to visit those employees who call in sick, to see if they can provide any assistance to the employee. The company is charged on a fee per call basis. These calls are made on the first day of illness and are determined by the record kept by the monitor on telephone calls received. The nurses receive a list of names and addresses each morning at 11:00 a.m. of those reporting sick on the graveyard shift at night before, and those on the day shift of the same day. A report is received from each nurse by 3:30 p.m. the same day stating the condition of the employee, whether or not he was at home and any other comments relevant to the case. We also direct the nurses to call weekly on employees absent due to industrial injuries and those off on an extended illness.

An employee who is absent without notifying the company will be telephoned by the monitor and if he then reports sick, he will be visited by the nurse. The monitor co-ordinates the visiting nurse program and prepares monthly report by departments to

indicate the progress, if any, we are making.

It seems to me that a nurse who allows himself or herself to be used in this way does not act in a professional manner and does not properly exercise the discretion now allowed by the regulation relating to nurses under The Health Disciplines Act, 1974.

Employees would like to see the employer accept a certificate which indicates only that the person was unable to work by reason of ill-health and is now fit for work. It has been shown in many arbitration decisions that letters from physicians purporting to be medical certificates have long been treated with caution. As was stated in Re Steel Company of Canada Ltd. and U.S.W., Local 1005 (1975), 8 L.A.C. (2d) 298 at p. 302:

We should also add that in admitting [purporting medical certificates]...boards of arbitration must be circumspect in ensuring such reports are of probative value. Where as here the first report is merely a standard form of some three lines without any diagnosis or explanation of the nature of the illness and where on the evidence of the grievor himself [the physician] never examined him nor questioned him as to his health...little if any weight can be attached to them.

In Re Gilbarco Ltd. and Canadian Union of Golden Triangle Workers (1973), 5 L.A.C. (2d) 205 the appropriateness of the medical certificate submitted in evidence was discussed at pp. 211-212.

We now must deal with the grievor's excuse that he was too ill to continue work and the doctor's certificate he filed in support of this allegation. As noted above, the grievor reported for work the following day. Some time later (perhaps on the Monday of the following week) the grievor went to his doctor and obtained the doctor's certificate on which he relied. While the doctor's certificate is admissible evidence, in the circumstances in which it was obtained it can only be classified as hearsay evidence. At the time the doctor saw the grievor he

was ready and able to work. The doctor obviously relied upon the grievor's statement that he was too ill to finish his shift on June 27th. The doctor's certificate merely makes the statement that MacMillan "has been absent from work June 27 due to illness". No diagnosis or explanation of the nature of the illness is set out in the certificate. The certificate itself is undated. The fact that such an inconclusive certificate was issued several days after the grievor was ready and able to work tends to diminish the probative value of that certificate. In making this finding we do not intend to set ourselves up as medical experts. We are merely assessing the evidentiary value of the doctor's certificate issued in the form set out above at a time when the grievor was not incapacitated by the alleged illness. Again, the fact that the undated certificate was not produced during the grievance tends to further lessen its evidentiary value. The form of the doctor's certificate and the manner in which it was acquired leaves much to be desired. Employers and trade unions would be well advised, for their own protection and also for the protection of employees, to make representations to the medical profession with a view to standardizing the form of certificates issued by doctors and to impress upon doctors the need to recognize their professional obligation to issue accurate and informative certificates. Two types of medical certificates are commonly required. One is required to justify the reasons for an absence from work. The other is required to certify the employee's fitness to return to work following an illness. It ought not to be too difficult to prepare standard forms for use by all doctors.

Employer concerns expressed to me were similar to those stated in these extracts.

The difficulty involved in requiring medical certificates for short term illnesses was stated in Re St. Jean de Brebeuf Hospital and CUPE (1977), 16 L.A.C. (2d) 199 at p. 205:

Many short-term illnesses, as any mortal human being knows well, are not amenable to medical treatment. Were the requirements of many collective agreements enforced to the letter, employees with common colds who ought to be home in bed with a warm drink would be forced to attend at their doctors' offices, and physicians who ought to be meeting with treatable medical needs of their patients would, to satisfy some employer, be certifying the existence of cold symptoms which can be best cured by the body's own defences.

Recommendation:

127. *That the Ministry of Labour in consultation with the Ministry of Health prepare a form that will be sufficient to:*

*(a) justify an employee's absence;
and*

*(b) certify an employee's fitness to
return to work.*

Once a medical certificate has been produced, there are several ways in which it is now retained by the employer:

- (i) Some employers store the certificate in the department responsible for payment of wages which requires it before making payment for the period of absence.
- (ii) Some employers require the certificate to be taken to the medical department where the company physician further examines the employee to ensure that he or she is fit to return to work. Sometimes an employee is declared fit but only for lighter duties until fully recovered.
- (iii) In the case of some employers, the certificate is given to the immediate supervisor who may or may not retain it.

A questionnaire was sent to 25 ministries of the Government of Ontario. Responses were received from twelve of them and personal interviews were conducted with members of five other ministries. The responses are discussed in more detail in the section of this report on Ontario government employee health

information. For present purposes it may be said that the responses received indicate that the right of access to the medical certificates is given to a fairly large number of persons and that the certificates are often copied so that they can be filed in more than one place.

The medical department should be responsible for accepting and storing the certificate. Where there is no medical department, a senior person in the department, branch or unit in which the employee works should have the authority to advise those responsible for payment that the employee is entitled to be paid for the period of absence. No copies should be made of the certificate which should be kept in a locked cabinet separate from the employee records. Access to the certificate should be restricted to those having authority to accept it. Where payroll information is stored on a computer, the reason for the absence should not be referred to on the computer tape.

Recommendations:

128. That the medical department be responsible for accepting medical certificates for short term sickness and advising those responsible for the payment whether or not payment should be made for the period of absence. The certificates should be retained and filed in the medical department.

129. That where there is no medical department,

(a) depending on the size and organization of the employer, a senior person in each department, branch or unit be given the authority referred to in the preceding recommendation; and

(b) no copies be made of the certificates, which should be kept in a locked cabinet.

Sickness and accident benefits, provided for in collective agreements, may, in some cases, be covered by an insurance policy taken out by the employer for the benefit of the employees to cover loss of wages due to an illness or injury. As is pointed out elsewhere, some large employers accept the claim form from the employee containing a diagnosis from a physician,

make sure that the form is properly completed, add employment details if necessary and then pass it on to the insurer. Other large employers act as agents for the insurer by processing the claim and issuing a cheque to the claimant on behalf of the insurer. Many large employers employ special personnel whose jobs are to process sickness and accident claims. In smaller enterprises, where the number of claims are fewer, one person's duties may encompass many different aspects of personnel work, of which processing sickness and accident claims is but one. Sometimes this leads to an attitude that health information about an employee is not especially confidential since the personnel branch has access to it in the long run when the application for sickness and accident benefits is made. That this is so is shown by the following answer given to me by Mrs. Stuart, the personnel manager at Dare Foods Ltd., when I asked her of the duration of the absence of the employee who had been sent home because of a skin problem.

He was only off for Friday, Saturday, Sunday, Monday. Four days. So it did not develop into a weekly indemnity claim. Had it developed into a weekly indemnity claim, of course, our department would have sent him a form to be completed by his doctor and I would have seen the diagnosis anyway. So it really wouldn't have mattered at what stage I saw it. [emphasis added]

To prevent this type of attitude from developing, claim forms containing a diagnosis of illness or injury for sickness and accident benefits or other benefits should be sent directly to the insurance company and the employer should be prohibited from requesting a copy either from the employee or from the insurance company. Where it is necessary for employment information to be obtained by the insurance company, a separate form should be prepared which can be given to the employee to complete. He or she may then obtain assistance from the personnel department or the person who has the necessary information at the employer's office, without the employer being made aware of the disability.

Recommendation:

130. (1) That where an employee makes a claim on a sickness and accident insurance or other insurance policy provided by the employer the claim form be sent directly to the insurance company and not to the employer.

(2) That the employer be prohibited from requesting a copy of the claim form containing the diagnosis from either the claimant or the insurance company.

(3) That a separate form be prepared for employment information necessary to complete the claim.

These recommendations have no application to those situations in which the employer acts as an agent for the insurance company, that is, when the employer processes the claims and issues a cheque on behalf of the insurance company. In these circumstances the personnel involved in administering the system should ensure that these files are kept separate from other employee records. Access to these files should not be allowed to other personnel without the authorization of the employees concerned.

These recommendations will prevent what was one of the most consistent complaints made by both individuals and union representatives, that is, that the forms required to claim sickness and accident benefits contained questions asking for excessive and unnecessary details of the medical conditions causing the claims. If that part of the form which contains the health information is not available to the management section of the employer, these complaints should cease.

Recommendations:

131. *(1) That where the employer is a self-insurer or acts as an agent for an insurance company for sickness and accident benefits, documents containing employees' health information be maintained separately from other records maintained by the employer.*

(2) That the information in these documents not be made available for use in making employment decisions.

(3) That access not be allowed to any other employee of the employer, including health personnel, without the consent of the individual concerned.

The form of the authorization on the claim forms for release of health information to the insurance company should be mentioned. This authorization should be so phrased that it is clear that the information required is pertinent to the medical condition in the form only, for example, "I hereby authorize the release to (the name of the insurance company) any information requested in respect of the disability for which this claim is being made."

Recommendation:

132. *That the authorization for release of medical information on a claim form be so phrased as to make it clear that the only information required relates to the disability for which the claim is made.*

William R. Loebach, the manager of compensation and benefits at the Chrysler Canada Ltd. plant in Windsor, gave evidence at our hearings in Windsor. His testimony was that the collective agreement, negotiated in 1976 between the company and the union, provides that when there was uncertainty whether a person who was receiving sickness and accident benefits was fit enough to return to work, an independent medical opinion must be obtained from a physician whose name is taken from a list jointly selected by the company and the union. The opinion of the physician as to whether the person is able to return to work is conclusive. The physician's report is forwarded to the sickness and accident department at Chrysler Canada Ltd. and also to the insurance company. The person examined is required to telephone the insurance company to ascertain if he or she is expected to return to work. The report received by the sickness and accident department is filed in that employee's file for that particular claim. The collective agreement states that a union representative with the authorization of the employee may inspect the report. Chrysler Canada Ltd. does not interpret this as allowing the employee personally to see the report. When asked to justify this anomalous practice, the answer was:

We have specifically said the union can. We haven't said the employee. That does not specifically say the employee can, so to be safe we are not permitting the employee.

I can see no good reason why the employee should not be entitled to access to this report also.

The brief submitted by the Ontario Occupational Health Nurses Association referred to the practice of some insurance companies of providing client companies with a year-end computerized data print-out of the number of claims, types of claims, and dollar value of the pay-out. Employees are referred to either by certificate number (of the claim form) or by name. If illnesses are referred to by code, the code book is usually forwarded along with the print-out. The information contained in the print-out can be useful to the client company but, unless the employer has a medical department, the employer should be entitled to year-end print-outs containing statistical data only, without information relating to individual employees. In the case of an employer with a medical department, the annual print-outs should be kept separate from other medical data generated on behalf of the individual employee.

Recommendations:

133. *That information relating to health and accident claims of employees provided by an insurance company to an employer consist of statistical information only without identifying employees, except when given to the medical department of the employer.*
134. *That where information which identifies employees is given to the medical department, it shall not be available for use in making employment decisions.*

Under The Workmen's Compensation Act, a worker may claim compensation for an injury which is work related. The claim is started on behalf of the employee by the employer filing a Form 7 with the Workmen's Compensation Board within three days of the cause of the injury. In addition, the Board has jurisdiction to allow certain illnesses, which have been accepted by the Board as being occupationally caused, to be treated as industrial illnesses for which compensation is paid to the claimant or to an employee's widow or widower. Apart from the need and desire for an employer to keep, for its own purposes, a record of all accidents in the workplace and of all occupational illnesses, it is obviously necessary that the employer be informed of such occurrences to enable it to comply with the requirements of the Act. In larger establishments there may be a special section of the personnel department which administers claims under the Act.

Edward Fedory, who gave evidence at our Windsor hearings, was a workmen's compensation administrator for the Ford Motor

Company of Canada Ltd. He testified about the procedure followed in the workmen's compensation department of that large employer. It is the practice there, according to his evidence, when an injured workman has been absent for some time, to write to the treating physician, on Ford letterhead paper, requesting a progress report on the employee. The following responses were given to questions put by Mr. Strosberg:

A. ...then I will send a treatment memorandum to the treating doctor.

Q. What is that?

A. It is just a note asking the doctor for his diagnosis, possible prognosis, and there is a section there to complete on a possible return to work date.

MR. COMMISSIONER: Is it a printed form in which you fill in the name of the patient, or is a letter sent out?

Q. Does it explain it is related to a Workmen's Compensation Board injury?

A. Oh yes, yes.

Q. It bears the logo of Ford Motor Company?

A. Yes.

Q. And is there any authorization of the employee sent along with this?

A. No.

Q. Do you just send the form?

A. I just send the form.

Q. Do you invariably get a reply?

A. Nine times out of ten I get a reply.

Q. Now you have got that report from the doctor which would set out diagnosis, prognosis and anticipated return date to work. What do you do with that?

A. Put it back into that lost time drawer with the man's file.

Q. Do you send a copy of that on to the Workmen's Compensation Board?

A. No.

No consent to this request or authorization for a report to the employer is included. This report is for the employer only and is not sent on to the Board. It is logical to assume that in most instances, if not all, the employee will want the employer to be kept up-to-date on his or her progress. However, this information should not be requested without the employee's consent. This will ensure that he or she is aware of what is being done. I am not sure how widespread the practice just discussed is. I suspect it and the practices about to be mentioned are quite common.

According to Mr. Fedory, if the Board requests information from the workmen's compensation section relating to previous claims, any relevant information Ford has in its files is forwarded as requested. The other practice which Mr. Fedory mentioned and which, again, is probably common procedure is for the Board to ask the employer's workmen's compensation section whether there is any record of any prior injury or illness in respect of which the claim is being made. For this request, access is sought to the files kept by the sickness and accident department. The workmen's compensation administrator is allowed access to these files on a "need to know" basis, and reports to the Board accordingly.

In order to fulfil its mandate, the Board has a duty to "examine into" all matters and questions relating to the question of eligibility for compensation, under section 74(1) of The Workmen's Compensation Act, as amended by S.O. 1973, chapter 173, section 8. One question that is of direct interest to the Board is whether the injury is properly attributable to the employment. For that reason the Board seeks to learn whether the claimant had any previous similar disability.

The duty of the employer to report information to the Board is as follows under the Act (as amended by S.O. 1973, chapter 173, section 1):

117.(1) Every employer, within three days after he learns of the happening of an accident to an employee in his employment by

which the employee is disabled from earning full wages or that necessitates medical aid, shall notify the Board in writing of,

- (a) the happening of the accident and the nature of it;
- (b) the time of its occurrence;
- (c) the name and address of the employee;
- (d) the place where the accident happened;
- (e) the name and address of the physician or surgeon, if any, by whom the employee was or is attended for the injury,

and shall in any case furnish such further details and particulars respecting any accident or claim to compensation as the Board may require.

I do not read this subsection as giving the Board the right to obtain from the employer health information relating to any prior injury or illness. The Board has the right to obtain health information under section 52 of the Act (as amended by S.O. 1973, chapter 173, section 1):

Every physician, surgeon, hospital official or other person attending, consulted respecting, or having the care of, any employee shall furnish to the Board from time to time, without additional charge, such reports as may be required by the Board in respect of such employee.

Accordingly, the Board may properly request the information from a company physician or nurse. The information is not necessarily in the physician's records on the employee and the physician or nurse may need to go to records held by either the workmen's compensation or sickness and accident sections.

In some instances, the company physician or nurse may be the health professional who completes the form required by the person treating the claimant, that is, Form 8. This form requires that details of a previous similar disability be

disclosed. When Form 8 is completed by a physician who is unaware of such previous similar disabilities, the Board will contact the employer for the information.

The only exception to the statement that there is no duty on an employer, as opposed to physicians and other health professionals caring for an employee, to provide information relating to prior health records of an employee, is with respect to hospitals in their capacity as employer. Section 67(1) of Regulation 729 under The Public Hospitals Act states:

The administrator shall keep a permanent record of all examinations and tests of every employee of the hospital and, if requested, shall send a copy of every record, including the X-ray films, to The Workmen's Compensation Board, to the Department or to the Commission.

Section 33(1) of Regulation 689 under The Private Hospitals Act, R.S.O. 1970, chapter 361, is in almost identical terms, as is section 19(2) of Regulation 578 under The Mental Hospitals Act, R.S.O. 1970, chapter 270.

As the information can properly be obtained from the company physician or nurse, I think that the Board should direct its inquiries to the medical department of the employer. A copy of the information forwarded should be given to the employee; where there is no medical department, the information ought not to be forwarded to the Board without the employee's consent. This will ensure that a claimant is aware of all information relating to his or her claim received by the Board.

Recommendations:

135. *That where the employer maintains a medical department, all requests from the Workmen's Compensation Board for information relating to previous similar disabilities be directed to the medical department.*
136. *That where medical information is forwarded to the Workmen's Compensation Board, a copy be given to the claimant.*
137. *That where no medical department is maintained by the employer, no*

information relating to previous similar disabilities be forwarded to the Workmen's Compensation Board without the authorization of the claimant.

Smaller employers, in respect of whose employees a smaller number of claims is generated, may keep records relating to the claims in their medical departments or in the personnel department as part of the employees' personnel files; in some instances there may be a special drawer for Workmen's Compensation Board claims, depending on the number of claims that is generated each year.

Where there is a large number of Workmen's Compensation Board claims generated because of either the number of employees or the type of enterprise being carried on, or both, and where the employer has a medical department, the section or persons responsible for administering these claims on behalf of the employer should be made a part of the medical department. This does not mean that these persons should have a right of access to other records in the medical department but, if this is done, the importance of the confidentiality of the information that they are handling will be better appreciated by them. Where there is no medical department, the persons responsible for processing the claim on behalf of the employer must ensure that the claims are kept separate from other records on the claimant and are not accessible to other members of management.

Recommendations:

- 138. That where an employer has a medical department, those persons responsible for administering workmen's compensation claims on behalf of the employees be made part of the medical department. The persons who become part of the medical department, with the implementation of this recommendation, should be denied access to other records generated by the medical department.*
- 139. That where there is no medical department, the persons responsible for processing the claims on behalf of the employer ensure that the claims are kept separate from other records on the claimant and are not accessible to other personnel.*

The evidence of representatives of the automobile industry was that, if the processing of a workmen's compensation claim is expected to take a long time, the employee will usually be allowed to receive sickness and accident benefits, with reimbursement occurring if and when the compensation claim is successful. There is, therefore, often the need for an exchange of information relating to the claimant between the workmen's compensation section and the sickness and accident section when this process is taking place. I do not know when the claimant is advised that this is being done. No doubt the claimant is content that something is being done to ensure that he or she will receive some compensation, whether it be from the Board or from sickness and accident insurance. Before any exchange takes place, however, the claimant should be told what is happening, and his or her consent to the exchange of information between the sections should be obtained.

Recommendation:

140. *That where a claim is transferred from workmen's compensation to a claim under sickness and accident benefits or short term illness benefits the claimant be advised and his or her consent be obtained before his or her health information is transferred.*

Some occupational health nurses have complained that, when they complete Form 8, they are required to set out any previous similar disability, whether work related or not. They consider this requirement to be a breach of confidentiality on their part. As I indicated previously, this question is properly within the jurisdiction of the Board. Section 52, which is set out above, creates an obligation to provide this information on any "person attending, consulted respecting, or having the care of any employee". My reading of this section is that it imposes a duty, on nurses as well as physicians, to forward a report as required by the Board. This is one instance where the balance of competing interests, that of confidentiality as against the interest of the Board in obtaining the relevant information, has been resolved in favour of the Board by the Legislature. I do not see any reason to suggest any interference with this resolution. If a duty is imposed on physicians as persons who would necessarily have the relevant information, a similar duty properly falls upon nurses.

There is evidence that a number of collective agreements provide for the entitlement of employers to health information

of members of the bargaining unit. I refer to such occasions as a return to work after a period of absence as a result of illness. The existence of such a right in management is a reflection of the collective bargaining process. The individual employee's right to bargain and, for example, to protect his or her privacy, is superseded by the right of the union to act as the exclusive bargaining agent for all the employees in the bargaining unit. Although it is demonstrable that, generally speaking, unions are sensitive to the privacy interests of the employees on whose behalf they bargain, the bargaining process no doubt often compels both parties to trade off certain rights and interests in favour of those thought at the time of bargaining to be more important. In my opinion, it would be inappropriate for me to make recommendations that may have the effect of circumscribing the scope of free collective bargaining. It is not improper of me, however, to express the hope that, in the collective bargaining process, high priority will be given by both parties to the employees' privacy with respect to health information.

An issue which was brought to my attention by a local union that is the bargaining agent for the employees of an automobile manufacturer relates to the restrictive language of section 44 of The Health Insurance Act, 1972, S.O. 1972, chapter 91. The problem is essentially a wider matter than one arising out of the employment relationship but, because of the way in which it arose, I shall discuss it here. Many members of our society do not find it easy to complete the many forms that are required by the exigencies of modern life and therefore seek and obtain the help of others. Sometimes those others are friends, relatives or professional persons. At other times they are officers of a union. The same sort of assistance is often requested with respect to communication with government ministries or branches of ministries, perhaps for the purpose of obtaining information to fill out forms. One of these government agencies is the Ontario Health Insurance Plan. Some of the reasons for making inquiries at the offices of OHIP that became apparent during the inquiry are the following:

- (1) Often confusion arises over the currency of premium payments when an employee transfers from one employer to another and therefore from one OHIP subscriber group to another. Employees often seek help from the union insurance representative in connection with their status with OHIP. Another problem arises when an employee marries, particularly if his or her spouse has been paying OHIP premiums in another subscriber group; the problem is to ensure that the spouse is covered by a family group and does not continue to pay separate premiums. Of course, the

same difficulties are confronted by persons who are not "employees" but who turn for help to others. The same can be said for the remaining examples of problems encountered in this context.

- (2) In many instances employees who take vacations out of Ontario may need to seek medical assistance because of a sudden illness. OHIP provides coverage for out-of-province care in these emergencies, but often, particularly if one goes to the United States, the OHIP coverage is not sufficient to meet the actual cost. An employee may want to know the exact amount that OHIP will pay so that any supplementary health insurance plan of which he or she may be a member will be able to make up the difference in actual payment.
- (3) The question sometimes arises whether OHIP covers a particular fee claimed by a physician. It will arise with increasing frequency if more physicians opt out of OHIP and charge more than is allowed by the OHIP schedule.
- (4) If an employee has been laid off and the OHIP premiums are not paid by the employer during the lay-off, it may be necessary to ascertain whether an employee was covered by OHIP at a specified time.

The type of information which is required is not information relating to the person's medical condition but rather it is information concerning details of payments and how the claim should be completed. Prior to allegations that police were improperly obtaining information from OHIP, OHIP employees co-operated in assisting in these matters and, often, representatives of the subscriber were the persons who communicated with OHIP. After the allegations, OHIP management sought to tighten the procedures and co-operation with representatives was no longer forthcoming. All correspondence was sent directly to the subscriber and his or her representative was told to obtain the information directly from the subscriber. This meant delay and often inconvenience for the person who needed the information.

Section 44 of The Health Insurance Act, 1972, as amended by S.O. 1974, chapter 60, section 9, provides that:

(1) Each member of the Medical Review Committee, every practitioner review committee, the Medical Eligibility Committee and the Appeal Board and each employee thereof, the General Manager and each person

engaged in the administration of this Act and the regulations shall preserve secrecy with respect to all matters that come to his knowledge in the course of his employment or duties pertaining to insured persons and any insured services rendered and the payments made therefor, and shall not communicate any such matters to any other person except as otherwise provided in this Act.

(2) A person referred to in subsection 1 may furnish information pertaining to the date or dates on which insured services were provided and for whom, the name and address of the hospital and health facility or person who provided the services, the amounts paid or payable by the Plan for such services and the hospital, health facility or person to whom the money was paid or is payable, but such information shall be furnished only,

.

(d) to the person who received the services, his solicitor, personal representative or guardian, the committee or guardian of his estate or other legal representative of that person; or

.

I do not think that the assistance sought by the subscriber in the situations outlined above is possible under section 44(2)(d), and it seems to me that a person should be entitled to seek assistance in these and similar situations.

Recommendation:

141. *That The Health Insurance Act, 1972 be amended to make it possible for any authorized representative of a person personally entitled to information from OHIP to receive any information that person may receive.*

Ontario Government Employee Health Information

Concern has been expressed over the role of the Province of Ontario (more accurately, the Crown in the right of Ontario) in respect of its practices relating to employees' health information. It extended to such matters as the location of the storage of employees' health information and the means by which it is acquired. The Province is one of the largest employers in the nation. In December, 1979, there were 75,870 persons employed under the provisions of The Public Service Act, R.S.O. 1970, chapter 386. This Act divides persons employed by the government of Ontario into two categories, classified and unclassified (see section 1, subsections (b) and (i)). I.H. Jennings, the director of Administrative Services of the Civil Service Commission, made the following distinction between the two categories at our hearings:

Public Servants then are divided into two categories. They are people appointed under the Public Service Act and they fall into two categories. Classified staff, which is a synonym for civil servant, and they are the people appointed to the classified service. They are basically the people whose positions are considered to be on-going, long term career type of individual. The other half or the other portion of public servants...excuse me. Let me step back a second. Those people are appointed by the Commission or on the certificate of the Commission by the Lieutenant Governor in Council.

The other portion of public servants is called unclassified staff, and they are appointed under the authority of the minister in each ministry and are, generally speaking, the part time, short term projects staff etc. A few special situations, a minister's executive assistant, etc., where the job may be ongoing though the person may not be.

The size of the unclassified staff varies at different times of the year. Appointments are generally for one year or less at a time, and usually for a total of no more than three years. Under Regulation 749 (as amended by O. Reg. 38/71, section 1) under The Public Service Act there are two groups of unclassified employees. Group 1 is typified by students on individual contracts, the temporary secretarial pool ("GO Temp"), staff working under 24 hours a week, special or professional appointments, and staff for projects of a non-recurring kind. Group 2 employees are hired to fill seasonal positions, such as, for example, provincial park employees.

Another group of Crown employees, persons employed by Crown agencies, are appointed pursuant to the legislation creating the agency and not pursuant to The Public Service Act. Two examples of this category, I was told, are employees of the Ontario Research Foundation and provincial court judges.

The Civil Service Commission is established under The Public Service Act and is the body responsible for the administration of that Act and the regulations made pursuant to it. The role of the Commission is to establish policy for the guidance of the various ministries that make up the government "to apply across the government for the purpose of our employer and for the purposes of equity of treatment of staff," to use Mr. Jennings' words. He went on to say:

The Commission staff will provide advice or assistance to ministries on request in that policy and there is also a function of audit and review to make sure that the policy is complied with.

Much of the day-to-day personnel administration is done by individual ministries, who deal directly with their employees according to rules established by the Commission. The Commission has a staff of over 190. It produces a manual of administration, which is a looseleaf binder containing the policies of the government and guidelines as an employer with relation to its employees and guidelines for the implementation of those policies. Some ministries also have their own manuals of administration. I intend to refer to the Ontario Manual of Administration, the manual produced by the Commission, later.

One of the concerns to which I referred earlier was with relation to the implementation of section 74 of Regulation 749 (as amended by O. Reg. 1013/75, section 5), which reads as follows:

MEDICAL EXAMINATION

(1) After five days absence caused by sickness, no leave with pay shall be allowed unless a certificate of a legally qualified medical practitioner or of such other person as may be approved by the deputy minister is forwarded to the deputy minister of the ministry, certifying that the employee is unable to attend to his official duties.

(2) Notwithstanding subsection 1, the Commission or a deputy minister may require an employee to submit the certificate required by subsection 1 for a period of absence of less than five days.

(3) Where for reasons of health an employee is frequently absent or unable to perform his duties, his deputy minister may require him to submit to a medical examination at the expense of the ministry.

(4) The Commission may, at the expense of the Commission, require such further medical examination as it considers necessary.

Regulation 749 regulates the working conditions for public servants. Section 74 appears in Part VI, which is entitled "Benefits". Section 68(e), as amended by O. Reg. 1013/75, section 5 and O. Reg. 46/77, section 1, defines "employee" for the purposes of Part IV:

"employee" means a civil servant who is not within a unit of employees established for collective bargaining in accordance with any Act;

This then introduces another division that must be made between classes of public servants for the purposes of determining the conditions of employment that are applicable. The Crown Employees Collective Bargaining Act, 1972, S.O. 1972, chapter 67, specifies which public servants may be included within the bargaining unit for collective bargaining. Certain groups are excluded from the bargaining unit by section 1(g), the most relevant of which, for present purposes, are those in managerial positions, those employed in a professional capacity, and

- (vi) a person engaged under contract in a professional or other special capacity, or for a project of a non-recurring kind, or on a temporary work assignment arranged by the Civil Service Commission in accordance with its program for providing temporary help.

Thus, for the purposes of conditions of work, there are three classes of public servant: first, there are civil servants in management positions whose employee benefits are set out in Regulation 749. Second there are those who are eligible to belong to a bargaining unit and whose working conditions are set out in the collective agreement negotiated on their behalf by the bargaining agent. Part of the agreement respecting employee benefits negotiated between the Ontario Public Service Employees' Union (OPSEU) and Management Board of Cabinet, that is, that part relating to what is referred to as short term sickness plan, is set out in articles 13.9 and 13.10 which, for clarity, I reproduce again:

13.9 Where, for reasons of health, an employee is frequently absent or unable to perform his duties, the employer may require him to submit to a medical examination at the expense of the employer.

13.10 After five (5) days absence caused by sickness, no leave with pay shall be allowed unless a certificate of a legally qualified medical practitioner is forwarded to the deputy minister of the Ministry, certifying that the employee is unable to attend to his official duties. Notwithstanding this provision, where it is suspected that there may be an abuse of sick leave, the deputy minister or his designee may require an employee to submit a medical certificate for a period of absence of less than five (5) days.

The third class consists of certain unclassified staff, being those enumerated in section 1(g)(vi) set out above. Elizabeth Aboud, director of Disability Policy for the Civil Service Commission, said in her testimony:

Unclassified staff work under an individual contract and the individual contract will

specify their privileges as well as their responsibilities.

The only part of the individual contract under which these people work that relates to the health of the employee is in Part II, clause (G):

...attendance credits will accumulate at the rate of 1 1/4 days each full month in which the employee receives full salary. The employee who is unable to attend to his duties due to sickness or injury is entitled to leave of absence with pay debited to attendance credits. After five days absence caused by sickness, no leave with pay shall be allowed unless a medical certificate is produced.

The contract also provides for termination by either party upon giving a week's notice.

The Province has an Employee Health Services Branch which is part of the Ministry of Government Services. This branch has six physicians, one psychologist, 27 nurses, and seven clerical personnel on staff. It is found in 15 locations in Toronto. At the time of our hearings there were plans to open a regional office in Sudbury. The services provided are explained in the following exchange between Mr. Strosberg and Dr. W. O'Hara, now retired, but then the director of Employee Health Services:

Q. Could you outline briefly what services the centre offers to the employees? I understand this is a service just available to employees of the government of Ontario?

A. Yes, that's correct.

Q. What services are offered?

A. Okay. We provide services for employees who report conditions of ill health or accident. We provide consultative services, miscellaneous services such as immunization. We also provide a physical examination program for the government. Basically it's direct services for employees and advisory services to management on the health of employees through a system of physical examinations.

Q. That includes pre-employment examinations?

A. In certain categories of jobs, yes. And examinations for hazardous or dangerous working conditions. Extension medical examinations, superannuation medical examinations and certain type of request examinations.

Later Dr. O'Hara added further details:

MR. COMMISSIONER: Can I take you back a moment. If I understood correctly, and I think I did, your relationship with the employees is of various kinds depending upon the purpose for which the employee is there, a given employee. In some cases, I take it, you said immunization. It is as though you were that patient's physician, you or one of the other physicians in the service?

A. While they are at work, yes.

MR. COMMISSIONER: Yes. Or if they come to you because they have suffered an accident and need some first aid type of care?

A. Yes.

MR. COMMISSIONER: In other cases, for example, suppose you had a patient in the Hepburn Block who found it very convenient who had allergies and was taking shots during the year, found it convenient to have the shots in your service. Could he do that?

A. No. That's one thing we don't do.

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MR. COMMISSIONER: But there are some services which you provide which would be analogous to the services provided by a physician to his or her own patient?

A. Yes. While at work, yes.

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MR. COMMISSIONER: And in other cases, you are more like a third party physician reporting to an employer?

A. Yes. But...the reason that we provide the support services for medical services for employees is to enable them to stay at work whenever possible, or to attempt to shorten their period of illness by early intervention, or to support them in the case of an emergency until they can be taken to a hospital. It is not designed to take the place of a family physician.

The Employee Health Services Branch thinks of itself as a "maintenance service" only. This, in fact, is the way all industrial or occupational health physicians regard their function. They do not see themselves as taking the place of the employees' family physicians.

The fact of attendance at, and the results of examinations conducted by, the Employee Health Services Branch are not reported back to the ministry with which the employee works except when the attendance is for the tuberculosis testing required of every person employed as a public servant. A report is also sent to the ministry concerned when the employee attends for an examination pursuant to a referral by the ministry under section 74 of Regulation 749 in the case of management-level employees or under articles 13.9 or 13.10 for employees under the collective agreement. The examination is performed only if the employee consents to a report being sent. There is no provision for a mandatory referral for unclassified staff not within the collective agreement. As Miss Aboud explained:

They are not long-term staff and so the problem that you are, that might come up under mandatory medical assistance would never come up in their case.

There are no requirements set out for physical fitness in Regulation 749, the collective agreement negotiated by OPSEU, or the contracts under which the unclassified staff work. However, the Manual of Administration says this at page 6-55-1:

...every public servant shall take an x-ray test or a tuberculin skin test either before or as soon as possible after being appointed

to either the probationary staff or the unclassified service.

The employee may have the test performed by the Employee Health Services Branch or, where no government clinic is available, by an outside recognized agency for these tests. The reports sent to the personnel branch of the ministry concerned indicate that the person has attended for examination and whether he or she is suitable for employment. The results of the tests remain with the Employee Health Services Branch. The report is put into the employee's corporate file, that is, the file maintained for every employee which, though considered to be the property of the Civil Service Commission, is held at the ministry at which the person works and which moves with the person if he or she transfers to another ministry. The report made is of the kind contemplated by recommendation 120 found above. In the spirit of recommendation 124, results of the tests should be made available to the persons tested, if they ask for them.

Although neither The Public Service Act, nor the regulations made under it, set out health requirements, some job classifications with certain ministries do have such requirements such as, for example, correctional officers with the Ministry of Correctional Services and driver examiners with the Ministry of Transportation and Communications. Whether pre-employment medical examinations are done by the Employment Health Services Branch, by physicians employed by the ministry concerned, or by outside physicians, recommendations 120 to 125 should apply, so that the ministry is only advised as to suitability for employment with any limitation on employment noted, without disclosing the diagnosis or the reasons for the conclusion.

After an absence of five consecutive days, a public servant must provide a certificate from a legally qualified medical practitioner to be able to collect pay for the period of absence. This applies to all categories of public servants, whether classified or unclassified, and whether part of the bargaining unit or not. For both civil servants within the management class and those within the bargaining unit, the certificate is forwarded to the deputy minister of the ministry. The person to whom the certificate should be forwarded is not expressed in the case of persons working under contract. We sent a questionnaire to 25 ministries. Responses were received from 12 of them. Personal interviews were conducted in the case of five other ministries. The replies indicated an absence of a coherent policy among these ministries with relation to the place of storage of these or other health related certificates.

The 12 respondent ministries revealed that medical certificates may be placed in such different places as an employee's corporate file, the computer tape relating to that employee (Integrated Pay, Personnel and Employees Benefits System, IPPEBS), the files held by the branch of the ministry where the employee works, files of management staff relating to the employee, and the employee's personal file. Some ministries replied that copies of the certificate are filed in more than one place. Each ministry surveyed had a fairly lengthy list of personnel who had a right of access to the information. These are answers received:

- employee's immediate supervisor,
 - executive director of employee's division,
 - deputy minister and assistant,
 - all personnel branch staff (personnel officer, clerks, etc.),
 - senior branch management,
 - employee in presence of personnel officer,
 - programme manager,
 - staff relations officer,
 - IPPEBS staff,
 - accounts branch reconciliation clerks,
- e.g.

As medical certificates support leave-of-absence with pay the documentation is retained for audit examination by the Office of the Provincial Audit or under one or two year cycles.

- ministry internal audit staff
- civil service commission personnel audit staff.

Under the current scheme the medical certificate is supposed to be sent to the deputy minister, except for the case of contract employees, in respect of whom the destination is not expressed. In actual practice the deputy minister rarely sees the certificate. It is more usually received by persons in personnel or payroll departments or by supervisory staff at the branch or field unit where the employee works. In this connection, the reply from the Ministry of Natural Resources identifying the persons who have access to the certificate is illuminating:

(1) All Ministry supervisory staff EXCLUDED from the bargaining unit.

(2) All Ministry staff in both Main Office and the Field Organization whose responsibilities include any personnel professional, technical, clerical, stenographic, typing duties, i.e. Regional Personnel Officers and support staff; support staff to those in (1) above; Group Administrative Assistants and support staff.

(3) Personnel Services Branch.

(4) Supervisor, IPPEBS Section and support staff.

A more coherent policy is necessary in order to assure employees that the certificates required after a five-day absence are not generally accessible. No copies should be made of the certificate. Authority should be delegated to one person to advise the payroll department that the employee has satisfied the requirement and is entitled to be paid for the period of absence. This person should be the senior officer of the department, branch or field unit in which the employee works. In accordance with recommendation 129 above, certificates should be kept separate from other employee records. This will require an amendment to section 74(1) of Regulation 749 to allow the deputy minister to designate the appropriate person to whom the certificate is to be forwarded. Similarly, for contract staff, the person with authority to receive the certificate should be designated in the contract. This must be achieved through the bargaining process in the case of employees covered by the collective agreement. There should be no need to place the certificate in the corporate file, or on the IPPEBS tape which should only show that the employee was absent, and that the absence was approved by the appropriate authority.

These recommendations also apply where the deputy minister, (or under the collective agreement, the employer, that is, the Crown in right of Ontario) requires the employee to submit a certificate even though the period of absence is for less than five days. The collective agreement stipulates this may be required "where it is suspected that there may be an abuse of sick leave". Our survey indicated that certificates are required for this reason, as well as when there is a recurring or frequent pattern of absences for periods of less than five days. As with certificates for a five-day period of absence, these certificates are obtained by the employee from his or her own physician.

Another requirement, the one that causes the most concern, is that known as a "mandatory referral". This is the right of deputy minister or his or her designee (or the employer, under the collective agreement) to require an employee to submit to a medical examination, "where for reasons of health, an employee is frequently absent or unable to perform his duties...." (See section 74(3) and article 13.9 of the collective agreement.) Mandatory referrals do not apply to contract employees. Section 74(3) was first enacted in 1963 and has been carried forward in substantially the same form.

A mandatory referral is used when the employee's job performance is unsatisfactory because of frequent or excessive absenteeism or poor work standards, in order to determine whether a health problem exists. The attitude of the Province, as an enlightened employer, is that, if a health problem is the cause of the unsatisfactory performance, the employee should be helped to achieve better performance levels; if there is no health problem disciplinary action, including dismissal, may be taken if performance is not improved. An employee is advised that, because of performance problems, he or she is to be referred for a medical examination and that his or her consent will be requested to a report being sent to the referring personnel for evaluation. The position of the managers in the referring ministry seems to be that if the employee does not sign the consent, there may be something he or she wishes to hide. Dr. Paul Humphries, senior medical consultant to the Ministry of Correctional Services, put it this way:

Therefore, if the individual is indicating that he is not comfortable in our receiving information back, then automatically it raises question marks in our mind because the intent of this would be to assist the person, not to create problems.

The question that arises is the extent to which the consent given by the employee for a full report of his or her health is a true consent. Implicit in the proceedings is the fact that if the employee's performance cannot be justified on health grounds he or she may be dismissed.

Although an employee who refuses to attend for a mandatory referral is not subject to dismissal there exists a certain degree of moral suasion influencing attendance. The reasons for a mandatory referral fall into two categories. The first is a suspicion of alcoholism and the second is a suspected health problem not related to alcoholism. In the Ministry of Health, all mandatory referrals for suspected alcoholism are channelled

through the director of the Human Resources Branch but mandatory referrals for other medical problems are made by the designated senior management personnel, some 40 persons who have delegated authority to make referrals. In the case of a mandatory referral for alcoholism, the employee is requested to sign a letter in the following form:

I have been informed by the Administrator of
that your work performance is causing
concern and that you may be experiencing
difficulties with alcohol.

It has therefore been decided to refer you to the Employee Health Services Branch, Ministry of Government Services, for a medical assessment. Should treatment be recommended your co-operation with the treatment agency selected will be a condition of your continued employment. If no illness is diagnosed, normal disciplinary procedures will apply to any future infraction of the rules, or inability to adhere to usual standards of performance.

The administrator has been requested to hand this letter to you, and explain in detail the conditions which govern such referrals. This is not a disciplinary action, but an attempt to help you to overcome the difficulties you are experiencing. However, if there is a failure to co-operate with the assessment and subsequent procedures, or if there is no improvement in your work, the ultimate result will be termination of employment.

I am asking you to sign a copy of this letter to indicate that you have understood the situation and are prepared to co-operate. If you agree to do so, an appointment will be made for you through the Employee Health Services Branch.

Should treatment prove necessary, the Ministry of Health will provide all reasonable help during your rehabilitation period.

Yours very truly,

R. Oss
Director
Human Resources Branch

This letter has been discussed in the presence of

_____ Administrator
_____ Supervisor
_____ Personnel Officer
_____ Employee's
_____ Representative

This letter has been read and understood by me, and I agree to its conditions.

DATE _____ Employee's Signature _____

Not all mandatory referrals go to the Employee Health Services Branch. An employee may choose a private physician. Except for those employees who are based in northern or remote areas, most of the mandatory referrals do go to the Employee Health Services Branch. Dr. O'Hara thought that most of the mandatory referrals for alcoholism go to his centre. The Employee Health Services Branch does not perform any service for the employee other than the examination. If further action is necessary, for example, where there is an alcoholism problem, the physician suggests a treatment centre or refers the employee to his own physician. However, the employee who is referred because of suspected alcoholism or drug abuse is expected to sign a release in this form:

RELEASE

TO: W.E. O'Hara, M.D.
Director,
Employee Health Services Branch,
Queen's Park, Toronto, Ontario

I have been advised and fully understand that if, as a result of a medical examination I am found to have any condition attributable to the consumption or use of alcohol or drugs, and such condition is reported to _____, or any other supervisory personnel or employment officer in the Ministry of _____, I may as a condition of employment:

1. Be required to undergo further medical examination;
2. be required to undergo treatment for such condition, either through you or through any other physician or agency to whom I may be referred;
3. be subjected to disciplinary measures;
4. be removed from employment in the Public Service of Ontario if such condition is not remedied.

Notwithstanding the foregoing, I hereby irrevocably authorize you:

1. To make a full and complete medical examination, including an investigation into my history and any medical records whatsoever pertaining to me, for the purpose of ascertaining whether or not I have any condition attributable to the consumption of alcohol or drugs;
2. to communicate and discuss any diagnosis, prognosis and information in connection with such condition to and with _____, or any other supervisory personnel or employment officer in the Ministry of _____ ;
3. to effect, either yourself or through any other physician or agency to which you may refer me, any treatment which in your judgment or the judgment of such other physician or agency may help to alleviate or remedy such condition;

4. to communicate and discuss the progress and results of any such treatment to and with _____; or any other supervisory personnel or employment officer in the Ministry of _____ .

I hereby waive any and all claims whatsoever which I may have against you or against any physician or other agency arising out of or in any way connected with such medical examination, communication of information and treatment.

I hereby state that I have read over and fully understand the whole of the foregoing, and voluntarily execute this Release.

DATED at this
day of 197

WITNESS:

(Signature)

I cannot understand why this release must be so wide. The same language is not found in the consent form used for an employee under mandatory referral for health problems not related to alcohol. The release in the form set out above is a release of any claim arising out of anything done by the physician, including a misdiagnosis or a missed diagnosis. I suggest that a release of this nature is not justified. It is even more difficult to accept when a valid question exists about the voluntariness of the execution of the release itself.

Dr. O'Hara testified that if an employee refused to sign the necessary consent the Employee Health Services Branch would not examine the employee. He also said that the employee is, in fact, not asked to sign the release until after some initial tests have been done:

The names of people who are having appointments with physicians are on a scratch pad at the desk and an employee coming in usually advises the receptionist that he is there for an appointment. The employee is taken by one of the nurses to an interviewing office and the essential information is

completed and a preliminary, the preliminary aspects of the medical examination are carried out, which would include a vision test, hearing test, electrocardiogram, urinalysis and haemoglobin.

And then the employee is taken by one of the physicians and the physician then asks the employee if they, in the case of a mandatory referral, if they know why they are here, if they understand the reason for the referral, if they have a letter from their ministry. If they say yes and they are perfectly in agreement with it, they are given a two page release and asked to read it, which outlines the reason for the examination and the responsibilities of the medical staff.

In response to questions by Miss Smith, Dr. O'Hara gave these answers:

Q. I think we had got to the point of the doctors seeing the referred employee and asking him whether he received the letter and then asking him or advising him of the situation and presenting him with the consent form, the consent or release form to be signed. At this point the employee has already undergone some tests, has he?

A. Yes.

Q. If the employee indicated at this point that he was not willing to sign the consent and release form, what would your procedure be?

A. If the employee at any time prior to this had indicated that he was not interested in the examination, the nurses would bring the employee to me or to one of the other physicians and then the same thing would happen at this point that we are talking about. If the employee says I do not wish to have this examination or I won't give consent, the examination is finished.

Q. There wouldn't be a case of your carrying out the examination and then determining that the report could not be forwarded?

A. No.

Q. You would just not carry out the examination in that case?

A. That's correct. Yes.

Under both section 74(3) of Regulation 749 and article 13.9 of the collective agreement the employer is, by necessary implication, given the right to receive a full report of the medical examination. Little purpose is served in the employer's requesting a medical examination if he or she is not entitled to learn the outcome of that examination. For employees covered by the collective agreement, the employee's right of privacy has been exchanged for assistance, as opposed to discharge, for an employee whose work performance has been unsatisfactory because of a health problem. For those whose employment benefits fall under section 74(3), the same trade-off has been imposed upon them by regulation, not by collective bargaining. The intended benefits to the employee are the same in both cases.

The report which the Employee Health Services Branch sends back to the Ministry concerned contains diagnostic information, and information about the treatment the employee is expected to undertake and the source of that treatment. The Branch maintains contact with the employee by receiving reports from the treatment agency or from the employee counsellor who is involved with the particular case. If an employee attends the Employee Health Services Branch on a voluntary basis, no report is sent to the employee's supervisors. However, if that employee is later placed on a mandatory referral, the information obtained from these previous visits is referred to in the report to the ministry. The employee is not always aware of this. This should be made known to the employee before the information is used and his or her consent should be obtained. The recommendations relating to informed consent are applicable in this connection, so that the employee may have an opportunity to see the report and to request any corrections that may be warranted. Since the Employee Health Services Branch does not provide a full treatment service to an employee, there may be notations of, for example, a suspected diagnosis which was not borne out by further tests completed by another physician. Unless the employee or his or her physician advises the centre of these results, the suspected diagnosis may still be on the file.

Although more comprehensive than most reports, the following is an example of a report sent to the referring ministry in a case of mandatory referral:

Report of Clinical Assessments:
January 10, 1979.

Referral Authority: Section 74(3) of
Ontario Regulation 749.

Present Employment Status: Working at the
time of examination.

Background Information: was referred
for a medical and psychological examination
to determine if he is fit to continue to
work.

Clinical status: In interview with the
undersigned, gave a history of exper-
iencing symptoms dating back to 1960, which
are compatible with the diagnosis of a
borderline psychiatric illness. However, on
examination this fifty-three year old man
who has been employed by the government
since 1956 was found to be generally free of
any currently existing major psychological
abnormalities.

 was well groomed and was generally
co-operative and genial. With the exception
of watching his diet, as he is diabetic, he
reports that his appetite and eating habits
are normal. He will typically obtain be-
tween five and six hours of sleep and does
not report experiencing fatigue. 's
thoughts were generally free of any clearly
defined delusional system, however, there
was some evidence of some mildly eccentric
beliefs. At the time of examination there
was an absence of any currently existing
hallucinations. This man's affect was
generally appropriate to the occasion, and
when queried as to whether his superiors
have ever questioned his competence,
became mildly irate and proceeded to appro-
priately defend his past job performance.
He was correctly oriented in all spheres and
possessed adequate knowledge of current

events. In response to tests measuring his abstraction abilities, was found to be somewhat concrete in his responses, however, this is more likely to be caused by his limited educational level than by any mental illness. Although 's intelligence was not formerly assessed, it would appear that he possesses at least average intelligence. In response to clinical tests for judgment, gave normal responses. There was an absence of any evidence to suggest that this man abuses alcohol or drugs.

In interview with Dr. T. Rewa, gave a history of multiple health problems including diabetes mellitus which was diagnosed in 1960. He reports being under appropriate medical care and most of his physical problems have improved and his diabetic condition is controlled by insulin and diet. Physical examination performed by Dr. T. Rewa was compatible with his medical history.

Employability: At the time of examination, was found to be employable on the basis of both his physical and mental health. His psychological history would suggest that may have experienced psychological problems for short durations in the past.

Recommendations and Conclusions: Because of this man's psychological history suggestive of a borderline psychiatric illness, was referred to Dr. S. Henderson, psychiatrist for further evaluation and treatment. He readily accepted this recommendation and was given an appointment for January 22nd at 3:00 p.m.

Pertaining to his physical health, Dr. Rewa indicates that he is under appropriate medical care and that his physical health problems do not interfere with his ability to perform his job.

In response to our survey question asking why it was necessary for a full report to be given, we received the following answers:

- Emotionally ill employees are difficult to assess in job terms,
- To ensure safety of employee and other staff,
- To anticipate future problems,
- Need to receive information respecting contagious diseases, particularly in case of employees living in construction or survey camps,
- Wish to consider employee's suitability for continuing former duties requiring physical effort, to determine limitations on type of work able to perform,
- Without diagnosis of conditions of epilepsy and diabetes, disciplinary action might result unfairly,
- As alcoholism is considered as an illness, we should also be specifically informed of this, in order to ensure that the right kind of assistance is provided, and the relevant supervisor counselled,
- Definitive information is required if disability income is anticipated,
- Doctor would have to have a complete understanding of jobs and occupations in order to make unequivocal employment decisions,
- Judgment by employer of proper duties would be impossible unless doctor's report was very precise, comprehensive.

Most of these reasons can be satisfied by forwarding to the Employee Health Services Branch a description of the employee's job. The Branch could then indicate whether any changes are necessary because of the employee's health problem. For those problems where assistance and counselling are indicated, it is the right of the employee to decide whether he or she wants the assistance. Only then should more detailed information be sent back and then only after the employee has seen the report and has had an opportunity to request corrections. With respect to the assertion that it is necessary to receive information respecting contagious diseases, The Public Health Act imposes a duty on the physician diagnosing the disease to prevent the spread of the disease. The duty does not rest on the employer. Arthur F. Daniels, the former director of personnel at the

Ministry of Correctional Services, when asked at our hearings whether it was necessary for the referring person to receive a great deal of diagnostic information, answered:

I think there's another thing. When I was director of personnel, although I don't think we referred that many to you, you know, of those many, many reports coming down from Dr. O'Hara and his staff. We would only read the last sentence. He was fit for duty or unlikely to return or should go on LTIP. We were really not too interested in that body of information.

Dr. O'Hara testified that on one occasion an employee, before signing the release, added a condition that only a report as to fitness to work was to be sent to the referring department. This condition was complied with. In the private sector, Chrysler Canada Ltd. has a programme that deals with alcoholism and drug abuse administered jointly by the company and the union. Dr. J. Schisler, the medical director at the Windsor plant of that company, gave evidence that he interviewed 90 per cent of the employees in the programme and that their records are kept strictly confidential. Even the secretaries in the medical department are given no access to them. If it is necessary for an employee in the programme to be absent from work, he or she is put on the sickness and accident benefit plan. The notation on the insurance claim form is "drug dependence or alcoholism". If recommendations 130 and 131 are implemented, the employer will not become aware of the reasons for the absence.

As with certificates received from the employee to justify a period of absence of five or more days, there is no consistency among the various ministries with respect to the place of storage of the reports received from the Employee Health Services Branch and the persons who have access to them. Again, as with those certificates, these reports should be kept in one place only and access should be restricted to the person made responsible for ensuring that the employees' work standards are maintained.

At the moment, the right of access on the part of the employee to his part or her health records varies with each ministry, some allowing the employee to see the information and others refusing. Both the Ministries of Natural Resources and Correctional Services have, in addition to the master collective agreement, a ministry collective agreement, containing this provision:

Employee Access to own File #15(a)(3)

An employee is to be made aware of any written commendation reprimand or adverse report, which forms part of his record of job performance at the time it is placed on his personal file, but shall not include privileged information such as medical reports. [emphasis added]

This is an unusual use of the term "privileged", which, in legal terms refers to documents or testimony that are protected from forced disclosure in judicial proceedings by certain persons who acquire the knowledge because of their relationship with the individual to whom the information relates. In Ontario such an evidentiary privilege extends to the lawyer-client relationship but it does not extend to the physician-patient relationship. As I have said before, I do not think it would be appropriate for me to make any recommendation that, if implemented, would circumscribe the scope of collective bargaining. I can only express the hope that this provision be renegotiated in the light of the views I have expressed about access to one's own health information.

During our investigation of the procedures used by the various ministries to collect information about government employees, it became apparent that a security clearance is required for certain positions. At least two ministries indicated that they either had previously used or are currently employing Equifax Services Ltd. (formerly Retail Credit Company of Canada Ltd.). For a description of the methods and ethics of this company, see the section of the report on Equifax Services Ltd.

The Workmen's Compensation Board

The Workmen's Compensation Board of Ontario is the creature of The Workmen's Compensation Act, R.S.O. 1970, chapter 505, as amended by S.O. 1973, chapter 173, section 1, and has the responsibility of administering the scheme under the Act for the payment of benefits to employees who are injured at work or who suffer from an industrial disease or of pensions to their surviving spouses. The Board also has other functions which are related to its main responsibility. These other functions include the provision of medical care either by the payment of medical bills resulting from compensable disabilities or by direct medical care provided by its Hospital and Rehabilitation Centre which is located in Downsview. As the name of the hospital suggests, rehabilitation services, both vocational and social, are provided as well as medical services. The Board also has the responsibility of raising the revenue to support the system, which is achieved through assessments levied on employers as a percentage of payroll, except for those employers who are self-insured under Schedule 2 in the regulations under the Act.

A claim by a disabled worker is commenced by the forwarding of a required form to the Board. In about 70 per cent of all claims, the claim is commenced by the employer completing a "form 7" on behalf of the employee, "Employer's Report of Accidental Injury or Industrial Disease." The other 30 per cent of claims are commenced by the filing of a "form 6" by the employee, "Employee's Report of Accident". Once a claim is initiated, the mandate of the Board, as stated in section 74(1) of the Act, as amended by S.O. 1973, chapter 173, section 8, is "to examine into, hear and determine all matters and questions" relating to claims for compensation. The Board has investigative functions relating to claims as well as adjudicative functions. The question that the Board must decide is whether the claim is one that falls within the terms of the Act, that is, "arising out of and in the course of the employment."

As stated in the brief submitted by the Board:

...the Board believes that it is operating under an enquiry system as opposed to an

adversary system with the result that there is a duty on the Board to obtain all the available facts before making a decision.

For a claim that does not involve any lost time, the Board is responsible for the payment of medical expenses; such a claim may also develop into a lost time claim or, more rarely, a claim for a disability award to the individual. These claims are administered by the no-lost-time claim section. A claim that involves lost time is sent initially to the primary adjudication claim section. It was estimated by the director of this section, A. J. Darnbrough, at our hearings, that the majority of claims, about 62.5 per cent of them, are allowed at this stage as obviously falling within the jurisdiction of the Board. Unless they are likely to last over 13 weeks, the claims are administered to termination by this section. The remainder, including those in respect of which the disability is likely to last over 13 weeks, are sent to the extended disability claim section where the claims are more fully investigated by obtaining reports from the worker or from the employer or fellow workers and more detailed diagnoses or reports from the treating physicians or hospitals. Once a claim is accepted, progress reports from the treating physician are also requested from time to time.

A claim that is refused by the claims adjudication section is referred to the review branch, the function of which was described by Mr. Darnbrough:

...if a decision is made by an adjudicator within the claims adjudication branch and that is a negative or adverse decision, then that decision is automatically referred to a review branch, which is a part of our division. The review branch's responsibility is to make sure that the evidence that has been assembled by the adjudications man is sufficient to make the decision and that they are satisfied with the recommendation of the adjudicator. If they are not, of course they offer additional inquiries and investigation and other consultations and so on before making a decision. The review branch's responsibility then is to make the decision and advise the parties concerned, providing them with all of the reasons, explanations for the decision, whatever that may be, and in concluding that decision to indicate the next level of appeal and the opportunity for appeal. In this particular

instance that you are referring to, the review branch would be indicating that there would be access to appeals by contacting the registrar of appeals. That's a totally separate function from the adjudication branch services division.

Where a claim is rejected by the review board, a letter is sent to the claimant explaining why the claim was not accepted and advising him or her of the right of appeal. Included with the letter is a pamphlet setting out the procedure to commence an appeal. This pamphlet is printed in five languages. A description of the appeal stages was given by G. William Reed, Q.C., Vice-Chairman of Appeals:

The appeal is from a decision of the claims review branch or it may be from one of the other review branches, but you are not interested in assessment, but there is a medical aid review branch. But the appeal, there must be a decision by one of these branches before it can get into the appeals system.

An appeal comes into the appeals system and well normally the files will then be screened by appeals adjudicators who will decide whether at that point they may be able to make a decision from the file and allow the appeal because of new and additional information that has come in in the meantime. They may have new doctors' reports in on which a decision can be made, and a decision may be made at that time from the file. Now that's in the minority of cases, I believe. It would be less than five percent probably of the cases where a decision is made from the file.

You see, an adjudicator, for instance, in screening the file will also screen it from the point of view of determining whether it's a matter that may well be, should be referred up to the Board for determination, or whether it should be heard by an appeals adjudicator, which is the first level of the appeals system. Most of the cases are referred for hearing before an appeals adjudicator, which is a hearing before a

single person. There are some fourteen appeals adjudicators at the present time and their function is to conduct a hearing and to hear witnesses to conduct such further investigation as may be necessary in order to get a complete understanding of the case and all the facts. They will then write a decision, a written decision.

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That is done both in Toronto and locally. There is a right of appeal from a decision of an appeals adjudicator to an appeal board panel of three commissioners. The appeal board panels similarly conduct hearings both in Toronto and in other centres in the province. They may of course in addition obtain further information following hearings in the way of further medical reports they think may be required, and in turn provide a written decision to the party. That is the final level of appeal. There is a right under section seventy-five of the Act to reconsider a decision and there are of course a number of cases where there are requests for reconsideration, but that is very briefly the appeals system.

Neither the claimant nor the employer is allowed access to a claims file. Once an appeal is started, or where an appeal is being considered, the Board makes available to the concerned party or parties a summary of the information on file which relates to the issues under appeal. The summary does not indicate the names of the physicians or of other persons supplying the information. After the appeal date has been fixed, access to the file is given to certain categories of persons. Neither the claimants nor all representatives chosen by the claimants are allowed access. Professor Terence Ison in his study, Information Access and the Workmen's Compensation Board (Ontario Commission on Freedom of Information and Individual Privacy Research Publication No. 4), at pages 76-77, lists the categories of representatives who are allowed to see a claims file:

1) Lawyers.

2) Articling law students, and any law student in a legal aid group or storefront office.

3) Lay representatives that assist workers, such as the Injured Workers' Consultants, but not representatives in all such groups. The criterion is that the representative must be at arms length, i.e., a regular representative of disabled workers whose role in relation to them is to act as their representative in communicating with the Board. Access is not allowed to any group of disabled workers who wish to represent each other.

4) A full-time union official, or another union official who is not in the same bargaining unit as the claimant, is allowed access. But a union official who is a fellow employee in the same bargaining unit as the claimant is not allowed access.

5) Members of the Legislature and their assistants.

6) Members of Parliament.

A representative of the claimant who is allowed access must produce a written authorization from the claimant and must also sign the following undertaking:

I hereby request to see the reports on the Workmen's Compensation Board Claim file of Mr.

I will undertake not to divulge to Mr. any information in the medical records, without his doctor's permission, that might adversely affect his physical or mental health.

I will undertake not to use such medical or other information publicly or for any other purpose except for his Workmen's Compensation Board appeal.

I find it difficult to accept the proposition, implicit in the undertaking, that one who stands in the place of another person has higher rights than the person he or she represents. As I have said elsewhere, unless his or her client expressly authorizes it, I do not believe a lawyer may give such an

undertaking having regard for the fiduciary obligation a lawyer owes to his or her client.

The reason usually given by the Board as a justification for the refusal to allow a claimant to see the file is that to do so would undermine the traditional physician-patient relationship. Patients traditionally are not given access to their medical records by their physicians; to allow them to see the reports at the Board would be an intrusion into that relationship. At our hearings, the further reason was given that there may be information on the record which the patient is unaware of and that the physician would not want the patient to see, as in the case, for example, of a diagnosis of a terminal illness which the patient may have, and which the physician may have decided to withhold from the patient. The viewpoint of the Board as expressed to me by Mr. Reed is that:

...the Board should not be the person giving that information to the injured worker. It should be, that's the responsibility of the injured worker's or the claimant's doctor.

It was stated at our hearings that no formal studies have been conducted to ascertain how frequently information of that nature of which a claimant is unaware may be contained in a file. In response to a question asked by Mr. Strosberg, Mr. Reed said:

...I would have to agree that this type of situation is not one that arises frequently.

It is also said that if the information that has been withheld from the patient by the physician is relevant to the claim, in communicating the reasons either for or against allowing the appeal, the information is referred to in the written decision. Mr. Reed said:

It will come out, oh, yes, if it is definitely related to, if it's material to the decision, if it's material to the adjudication.

The Board's brief said that, because there is a duty of confidentiality imposed on physicians,

The Board is also concerned that by widening the exception to confidentiality so that the patient sees his own reports, there is a danger of over-burdening the practitioners

of health care and diminishing the value of clinical service as well as exposing physicians to undue harassment and new legal risks.

This argument was also put to me by Dr. William McCracken, executive director of the Medical Services Division, when he attended at our hearings. The duty of confidentiality on physicians is directed only to the unauthorized release of information about a patient to a third party; it should not prevent the release of the information to the patient to whom the information relates. To allow a patient to see his or her own record is not an exception to the duty of confidentiality owed by a physician to his or her patient.

It has been suggested by Professor Ison, at page 82 of his study, that if a patient is given a right of access to see the records on his or her file in a physician's office, "the access of a worker to his file at the Board might follow, almost as night follows day." Mr. Reed, when asked if the Board's policy would change if patients are given a right of access to their medical records responded:

Well I think I would probably, I can only speak for myself, but I would say that is certainly going to make a difference. Because our fundamental position has been it should be the attending physician who should pass the information along. If that right is there to see the file...

MR. STROSBURG: Doesn't that really do away with the problem?

MR. REED: It would certainly cause the Board to re-think its position. No doubt about that. Oh, yes.

I have discussed the question whether a patient should have a right of access to his or her medical records, and have made recommendations that, generally, such a right should be recognized, subject to certain exceptions. There have been several studies completed in recent years which have favoured the right of a person making a claim to the Workmen's Compensation Board to have access to his or her medical records held by the Board: Report Number Three, Part V, 1971, of the Royal Commission Inquiry into Civil Rights, the Honourable James C. McRuer, Commissioner, at pages 2177-8; The Report of the Task Force on the Administration of Workmen's Compensation in Ontario, 1973,

at page 34; the Third Report of the Select Committee on the Ombudsman, 1977, at pages 64-8; as well as the study by Professor Ison.

In R. v. Workmen's Compensation Board, Ex parte Kuzyk, [1968] 1 O.R. 571, Mr. Justice Hartt granted an application for mandamus to compel the Board to produce to Mr. Kuzyk medical reports relied upon by the Board. Mr. Justice Hartt held that as the Board had granted a hearing of the appeal by Mr. Kuzyk, the refusal to produce the records was a denial of a fair and meaningful hearing. The decision to grant mandamus was reversed on appeal to the Court of Appeal in R. v. Workmen's Compensation Board, Ex parte Kuzyk, [1968] 2 O.R. 337, but this was based on a finding that the application for mandamus was premature because it had not been established that the claimant did not have access to the material from a source other than the Board, that is, from his physician, to whom the Board was prepared to give the reports without imposing restrictions on further disclosure. Mr. Justice Laskin in delivering the judgment of the Court of Appeal said, at page 343:

On the record before this Court, the bald question whether the claimant was entitled to the material is not ripe for determination.

The decision of the Supreme Court of Canada in Workmen's Compensation Board v. Rammell (1961), 31 D.L.R. (2d) 94, concerned a claim for compensation that was rejected because of the Board's conclusion that the accident on which it was based had not arisen out of and in the course of the employment. The Board had granted an oral hearing for reconsideration which did not result in a favourable decision. Certiorari was brought to quash the decision on the ground that the Board had failed to disclose to the claimant the grounds upon which it had based its decision. In rejecting the application for certiorari, Mr. Justice Judson, with whom the majority of the Court concurred, held, at page 101, that, on the facts, there had been no refusal of disclosure and no non-disclosure amounting to refusal and that this "made it unnecessary to determine the duty of the Board, if any, to disclose information on its files." Mr. Justice Cartwright, in delivering the only dissenting judgment, said, at page 96:

In the particular circumstances of this case it was...the duty of the Board to make full disclosure to the respondent of every item of evidence on which it proposed to base its decision including the contents of all

statements made to its inspector and the names of the persons from whom those statements had been obtained, and, having done so, to give the respondent a fair opportunity to correct or contradict that evidence.

The authority to obtain medical reports about a claimant is given in section 52 of the Act, which reads as follows:

Every physician, surgeon, hospital official or other person attending, consulted respecting, or having the care of, any employee shall furnish to the Board from time to time, without additional charge, such reports as may be required by the Board in respect of such employee.

Unless the claim has been initiated by a report sent in by a physician, upon receiving notice of the claim, the Board forwards to the claimant a form to be completed by his attending physician and any specialists to whom the claimant may be referred by either the Board or the attending physician. The Board also seeks medical reports from any hospital at which the claimant was treated. Medical reports may also be obtained from the Board's medical services department or from the Hospital and Rehabilitation Centre. Medical information sought by the Board is not confined to information about the compensable accident. Where there was a pre-existing condition or where past medical history is relevant, medical reports are obtained from the physicians who treated the claimant. The social and economic circumstances of the claimant may also be investigated.

In the discussion of the administration of workmen's compensation claims by an employer in the section of the report dealing with employee health information, I recommend that where a report is sent to the Board by a medical department of the employer, a copy of the information forwarded should be given to the employee. I see no reason why the claimant should not be given a copy of each and every report the Board receives that contains medical information about him or her. One argument against such a proposal that was put to me by the Board, in the context of the consideration of the question whether a claimant should be allowed to have access to his or her file, was that if claimants saw their medical records, physicians would be less forthright in the opinions they expressed to the Board. It was also said that it was necessary to protect physicians, particularly in small towns, in those situations in which they tell the

patient one thing but report something else to the Board. I do not find either of these arguments persuasive.

As to the first argument, in civil proceedings in Ontario, medical reports obtained by one party to the action cannot be used in the hearing of the action unless notice of the intention to use the reports is given to the other parties to the action; the other parties are entitled to have inspection of any reports referred to in the notice; see The Evidence Act, R.S.O. 1970, chapter 151, section 52. As was stated by the Report of the Task Force on the Administration of Workmen's Compensation in Ontario, 1973, at page 34:

The argument that making medical reports available to those affected by them will be a constraint on frankness was made at the time when the law of Ontario was amended so as to make such reports evidence in trials in the law courts. The fears then expressed appear to have been without foundation. The experience of the courts and of lawyers and judges associated with claims for personal injuries in the courts appears to have been that there is no reduction of frankness or completeness in medical reports as a result of the amendment.

Since our system of civil procedure already provides for medical reports to be made available in this way, I can see no reason why copies prepared for the Board should not be made available to the claimant. With respect to the second argument, there is no justification for protecting an intellectually dishonest practice.

The claimant is entitled to know what every physician reports to the Board that relates to his or her claim. Indeed, I suggest that, in any situation in which a physician is under a duty to forward a report about a patient pursuant to legislative authority, a copy of the report be sent to the patient unless there are valid reasons for not doing so, as, for example, in the case of a report on suspected child abuse. Even in the matter of suspected child abuse, the suspected abusers are now notified of the fact of the report and are allowed to see the information which the Ministry of Community and Social Services has about them, although the identity of the informant is not given for obvious reasons; see The Child Welfare Act, 1978, S.O. 1978, chapter 85, section 52, particularly subsections 3 and 12.

If a claimant receives a copy of the report forwarded to the Board, he or she will know what medical information is in the possession of the Board, and will then be in a position both to advise the Board of any errors that he or she feels the report contains and to provide the Board with information to make corrections if necessary.

Directive three of the Board's Orders and Adjudicative Directives Manual, as of February 7, 1979, at page 169, states:

One: Where a claim is rejected on medical grounds, there is to be no indication given by the adjudication branch to the employee claiming that his attending physician was the cause of the rejection.

Two: It is only at Board or executive level and also only as a very last resort that the actual statement of the employee's physician is to be given as a basis of rejection.

W. R. Kerr, the executive director of the Claims Service Division of the Board, said at our hearings, by way of explanation of this directive, that the claimant should be aware that responsibility for the rejection of the claim is that of the Board and not that of a physician. However, as stated by the Honourable James C. McRuer in the report of the Royal Commission Inquiry into Civil Rights (Part V, Report Number 3, 1971, at page 2178):

...the workman should be entitled to know on what material a decision involving his rights is based.

There will be situations in which a physician may be of the opinion that it would be detrimental to either the physical or mental health of a patient to provide him or her with a copy of the report. My conclusion, based on the evidence made available to me during the inquiry, is that only on a very few occasions may the practice be harmful. That is not a reason for preventing copies of reports from being sent in the vast majority of cases in which no one suggests that the patient would be harmed by seeing the information.

Where a physician is of the opinion that it would be detrimental to the patient to see a copy of the report, he or she should be prepared to justify that opinion. In the section discussing access to one's own health information, a recommendation is made that a Health Commissioner be appointed to

hear applications from physicians for exemptions from the general obligation to afford access to patients to their health information. I see no reason why the same procedure could not be used where there is an objection to providing the claimant in a workmen's compensation matter with a copy of the report sent to the Board. The Health Commissioner should therefore be available to hear such an application.

If a copy of the medical report is to be sent to the claimant, section 99 of The Workmen's Compensation Act will need to be reconsidered. This section reads as follows:

Every report made under section 52 and every other report made or submitted to the Board by a physician, surgeon, hospital, nurse, dentist, drugless practitioner, chiropodist or optometrist is for the use and purposes of the Board only, is deemed to be a privileged communication of the person making or submitting the same, and unless it is proved that it was made maliciously, is not admissible as evidence or subject to production in any court in any action or proceeding against such person.

Section 99 was enacted after the Report of the Royal Commission in the Matter of the Workmen's Compensation Act, 1967, perhaps better known as the McGillivray Report. Mr. McRuer commented on the section at pages 2175 and 2177 of his report:

...The amendment [as section 99 then appeared] appears to be based on a recommendation of Mr. Justice McGillivray, but the legislation is not in accordance with his report.

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It is quite clear that Mr. Justice McGillivray considered that the legislation making a physician's report privileged was only to be considered if the reports were to be shown to claimants. He clearly recommended that the present practice of showing the claimant only a summary of the medical report be continued. But if that recommendation was not adopted then he

recommended that there should be legislation making the reports privileged.

If it was only intended that physicians, hospitals, nurses, dentists, drugless practitioners, chiroprodists and optometrists should be safeguarded against actions for malpractice the statute could well have been framed to say so in clear terms.

We do not question the right of a professional man making a report to the Board without negligence and in good faith to the protection the law affords him. But we ask the question: Why should a member of any of the enumerated professions be protected against actions based on negligence with respect to reports to the Board while they are not protected in making a report to the patient or his insurance company? The exception in this section "unless it is proved that it was made maliciously" is not very meaningful. It would be most difficult for a workman to prove that a report was made maliciously unless he was permitted to see it.

The health-care practitioner who makes a report to the Board is granted a protection against successful defamation actions by the common law; see Halls v. Mitchell [1928] 2 D.L.R. at pages 113-114. I do not believe that he or she needs or is entitled to any further protection. No such protection was given to physicians when section 52 of The Evidence Act was enacted. I am of the opinion that the answer to the questions posed by Mr. McRuer in the passage quoted above is that there should be no such protection. In my opinion, section 99 should be repealed. Release of information to third parties is still forbidden by section 98 which says:

(1) No officer of the Board and no person authorized to make an inquiry under this part shall divulge or allow to be divulged, except in the performance of his duties or under the authority of the Board, any information obtained by him or that has come to his knowledge in making or in connection with an inspection or inquiry under this Part.

(2) Every person who contravenes any of the provisions of subsection 1 is guilty of an offence and on summary conviction is liable to a fine of not more than \$50.

Professor Ison notes in his study, at page 90, that some physicians, when asked by the claimants and their representatives to provide copies of medical reports, require a fee for this service. Section 52 states that the duty is to provide a report to the Board "...without additional charge...." As the sending of a copy of the report to the claimant involves little more than the making of a copy and posting it to the claimant, there should be no fee charged to the claimant.

Recommendations:

142. (1) *That when a report containing medical information about a claimant is sent to the Workmen's Compensation Board pursuant to section 52 of The Workmen's Compensation Act, a copy of the report be sent to the claimant free of charge.*

(2) *That when in the opinion of a health-care practitioner sending a copy of the report would be detrimental to the physical or mental health of the claimant, an application be made by the health-care practitioner to the Health Commissioner, referred to in recommendation 83, for an exemption from the obligation to forward a copy of the report to the claimant.*

143. *That section 99 of The Workmen's Compensation Act be repealed.*

If these recommendations are implemented, there will be no reason for the Board to refuse a claimant, or his or her representative, access to the medical records held by the Board at any time. There is also no reason for the Board to allow access to only certain classes of representatives chosen by the claimant and not to others. The claimant should be free to choose any representative he or she wishes to inspect the file.

A more difficult question is that of the right of access to the medical record on the part of the employer. The employer may be appealing a decision granting compensation to the claimant, may be opposing an appeal by the claimant from a decision denying compensation or, as noted by Professor Ison in his study at page 14, may be supporting an appeal by a claimant. The view of the Board is that, if a claimant is granted access to his or her medical records, the employer should be granted equal access as a matter of natural justice, and that this may work to the detriment of the claimant in that information may be contained in the file that the claimant would not want the employer to know.

The employer is not always involved in the appeal process. The following information was given to me at our hearings:

MR. COMMISSIONER: ...What is the frequency with which a claim that an injury is compensable made by the worker is contested by the employer?

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MR. KERR: We have no concrete figures on that, Mister Commissioner, but of the review branch they not only handle these recommended adverse decisions by the claims adjudication branch, but they also take a look at objections to decisions. Out of the 19,000 objections to decisions we had last year, 5,000 of them were from employers. I don't know how significant that is, but that's the only figures that we have on that particular area.

MR. REED: At the appeal board level, and these are not accurate figures, but we had...[in] 1978, 86 employer appeals as opposed to about ...1,029 by injured workers.

At the present time, an employer who is considering an appeal, or who is involved in the appeal process, receives the same summary of information in the file that the claimant receives. A lawyer representing the employer seeking access to the file must sign an undertaking similar to that signed by the claimant's representative. The form includes the following paragraph:

I will undertake not to divulge to M..... or the employer, any information in the medical records, without his doctor's permission, that might adversely affect his physical or mental health.

Employer representatives other than lawyers are not allowed access to the file.

The Board's argument is that the employer's right of equal access follows logically from the duty placed on the Board, as an inquisitorial body, to ensure that all relevant material has been obtained before reaching a decision. The Board also argues that it has an obligation to ensure that there is a fair hearing, and that each side has enough information to enable it to present its case and to meet the other side's case.

The following passage is taken from Professor Ison's study at pages 121-124:

Another view, which might be the prevailing view in the labour movement, is that the principle of equal access is wrong, and ought not to be conceded. The first argument is that making information on a claims file available to the worker is not primarily a matter of procedural due process but is primarily a matter of human rights. The file relates to a human being. His interest in knowing what it contains is infinitely greater than the interest of anyone else, and his interest is not limited to the preparation of argument for a pending decision. In other words, a worker should be allowed access on the same basis as people are allowed access to personal files in the federal system under the Human Rights Act.

Alternatively, even if access is perceived simply as a matter of procedural due process, it could still be argued that equal procedural opportunities are inappropriate because the interests to be protected are significantly different. The interest of a worker in a compensation claim is infinitely greater than any interest of a company. For the worker concerned, his livelihood, at

least for a period, and in some cases for life, may be at stake. For his employer, however, all that may be at stake would be an adjustment to his W.C.B. assessment, which in any event might be only a marginal item of business expense.

If compensation costs are considered in aggregate, rather than in relation to a particular claim, the argument does not significantly change. The costs in aggregate are, to some extent, borne by employers. But they are also to some extent passed forward in the price of products, or passed backwards as opportunity costs to labour.

An alternative, and perhaps stronger argument, is that the demand for greater access for a worker does not rest simply on the ground that he has greater financial interests at stake, but also that he has greater other interests.

It is workers who suffer the pain and anguish of industrial disabilities, and the fear of further deterioration. It is they who suffer any subsequent limitations on social life or future employment. In some cases, it is they who are rendered immobile. In the fatal cases, it is their widows and children who are left to mourn. Small employers are often exposed to the same risks. But corporations have no comparable interest in industrial disabilities. It may seem like a callous, and bureaucratic or legalistic, reaction to the human predicament to say that any procedural rights for the victims of disablement must be matched automatically by equal rights for corporations.

Again, the interest of a worker in personal privacy may be adversely affected by the disclosure of documents on his claims file to a company. But the company has no similar interest that could be adversely affected by the disclosure of documents on a claims file to the worker.

It is important to recognize here that medical reports do not always focus exclusively on a particular limb or organ that is primarily involved in a particular claim. They usually include medical and other information of a general nature about the worker, and they may include sensitive personal information. For example, if there is doubt about the etiology of a disability, one theory being employment causation, and another theory being events in the private life of the worker, the Board must investigate the evidence to determine which hypothesis is the more credible. Any medical report that is part of that enquiry might well, therefore, include a consideration of any causative factors (such as domestic problems) in the private life of the worker as well as causative factors in his employment.

An argument in support of company access to a claims file is that if such access were not allowed, corporate organizations might respond by demanding the promulgation of regulations under Section 21(2) of the Act, so that a worker claiming compensation might be required to submit to a medical examination by a doctor appointed by the company. This might well be resented by workers. In the Board and elsewhere, it might well be perceived as marking a step backwards towards the adversary system. If, therefore, it should become seen as the logical alternative to company access to claims files, the latter might be seen as the lesser evil.

However, in Welland Forge Limited v. United Electrical Radio & Machine Workers of America (U.E.), Local 523 et al. (1979), 27 O.R. (2d) 1, Mr. Justice Brooke, in a statement that was not essential to the disposition of the appeal, expressed the opinion that the process of requiring an employee to submit to a medical examination under section 21(1) of the Act might be available to the employer even though regulations had not been promulgated under section 21(2).

The alternatives are either to deny both the employers and their representatives access to the file, and have them rely on the summary provided, or to allow access to all representatives of the employer. I do not find acceptable the present situation in which the legal representative of the employer is allowed access upon the undertaking not to disclose certain information in the file to the employer, for reasons I have already stated.

In my view, employers and their representatives should be allowed access only when involved in appeal proceedings, on which occasions access should be restricted to those medical reports which are relevant to the issues in the appeals.

Recommendations:

144. *That the claimant and any person he or she chooses to represent him or her be allowed access to the medical records in his or her file at any time, unless a recommendation has been made by the Health Commissioner that it would be detrimental to the claimant to see the records or any part thereof.*
145. *That where the finding of the Health Commissioner is that it would be detrimental to the claimant to see a particular report, access be allowed to any other report in the Board's file.*
146. *That the employer and any person the employer chooses as a representative should be allowed access to medical records on the file where the Board is satisfied that,*
 - (a) there is an appeal from a decision of the claims adjudication branch; and*
 - (b) the employer has a genuine interest in the appeal.*

The access should be restricted to those medical reports or those portions of the medical reports that are relevant to the issue in the appeal.

When a claim is made by a dependent for the death of a worker, the Board may obtain from the Coroner's office a copy of any post mortem examination report about the deceased person. The brief submitted by Dr. H. B. Cotnam, Chief Coroner for Ontario, indicated that copies of these reports are released to the Workmen's Compensation Board in the exercise of a discretion under section 16(2) of The Coroners Act, 1972, S.O. 1972, chapter 98. Mr. Reed advised me that these reports have stamped on them the words, "Not to be released without consent of the Chief Coroner," and that the Board is therefore unable to allow the claimant to have access to these reports.

Section 16(2) of The Coroners Act, 1972 reads:

(2) Every coroner shall keep a record of the cases reported in which an inquest has been determined to be unnecessary, showing for each case the identity of the deceased deceased and the coroner's findings of the facts as to how, when, where and by what means the deceased came by his death, including the relevant findings of the post mortem examination and of any other examinations or analyses of the body carried out, and such information shall be available to the spouse, parents, children, brothers and sisters of the deceased and to his personal representative, upon request.

This subsection does not confer a discretion to make post mortem examination reports available to the Board. It simply creates a duty to give those identified in the subsection the information described when requested. Nor does any other section in the Act allow a copy of the report to be forwarded to the Workmen's Compensation Board. It may often be necessary for the Workmen's Compensation Board to have a copy of the report, and perhaps The Coroners Act, 1972 should be amended to allow the Chief Coroner to have the power to forward it to the Board when the findings in the report are necessary for a determination by the Board.

If such an amendment is made, however, there is no valid reason why the dependant of the deceased making the claim should not be allowed access to the report in the possession of the Board. "Dependant" is defined by section 1(1)(f) of The Workmen's Compensation Act and, for all practical purposes, includes the same persons as those to whom the copy of the report must be shown upon request. The employer is not a person contemplated

by section 16(2) as being entitled to receive information from a post mortem examination report. This makes sense in the context of The Coroners Act, 1972 since the persons who can receive the information are those interested in knowing the cause of death because of their relationship to the deceased. Where, however, the question in a workmen's compensation claim is whether the death "arose out of and in the course of employment" the employer becomes an interested party. The employer should not be denied access to the report in the hands of the Board if the cause of death is the issue in the appeal.

Recommendation:

147. (1) That The Coroners Act, 1972 be amended to allow the coroner to forward to the Workmen's Compensation Board a copy of the post mortem examination report when the report is required by the Board to enable it to determine a claim for compensation by dependants of the deceased.
- (2) That where a copy of the report is forwarded to the Board the claimant or his or her representative be allowed to have access to it.
- (3) That where an employer is involved in the appeal process the employer and any representative of the employer be allowed access to the report, if it is relevant to an issue in the appeal.

In its brief the Board said that:

...the Board considers the information contained in its files is for the sole use and purposes of the Workmen's Compensation Board. There are, however, exceptions to the rule.

Some exceptions noted in the brief were:

Reports of staff doctors at the Hospital and Rehabilitation Centre are sent to the family physician and specialists involved in patient's care.

Where the Board seeks the opinion of a consultant or medical referee, all of the medical information on file is sent to the consultant or medical referee.

Where a disabled employee is under the care of several physicians, each physician receives copies of all the medical reports concerning that employee.

Where the Board forwards copies of medical reports to other physicians, specialists, or consultants who are involved in caring for, or advising the Board regarding the claimant, a notice should be given to the claimant of this procedure. Presumably the claimant will already have received a copy of the report when it was received by the Board. Similarly, a notice also should be given to the claimant when a report is forwarded by staff physicians at the Hospital and Rehabilitation Centre to physicians involved in the patient's care. Access to these reports may then be sought by the claimant, if desired. The claimant should be aware of the fact that reports relating to his or her medical condition are being sent, and to whom.

Recommendation:

148. That when a medical report is forwarded to any physician by the Board or by the staff physicians at the Board's Hospital and Rehabilitation Centre, a notice to this effect be sent to the claimant.

Other exceptions mentioned by the Board are:

Industrial physicians are provided with limited information for the purpose of enabling them to participate in the rehabilitation of their company's employees.

Employers are supplied with a limited degree of information to allow them to assess the opportunities of re-employing the injured employee.

The objective of the Board in forwarding medical information about a claimant to an industrial physician is to assist in the rehabilitation of a claimant. At our hearings, Dr. McCracken reiterated that limited information is given and only

when it is necessary to involve the company physician in the rehabilitation of the claimant. In his study, Professor Ison says, at page 113, that the understanding of union officials is that medical information is sent whenever the Board becomes aware that the employer has a physician on staff.

I can see no objection to medical information relating to rehabilitation of a claimant or to suspicion of exposure to a contaminant used in the manufacturing process of the employer being sent to the industrial physician. However, before any information of that kind is sent, the consent of the claimant should be obtained after he or she has been shown a copy of the report and given an opportunity to request corrections. The recommendations in the discussion of the employment relationship are applicable. Management should not have access to this information and any change in job classification required should be indicated by the industrial physician without disclosing the diagnosis.

Recommendations:

149. (1) *That information given to a company physician relate only to the rehabilitation needs of the claimant or to suspicion of exposure to contaminants used in the manufacturing process of that employer.*
- (2) *That before information about a claimant is given to a company physician, the consent of the claimant to the release of this information be obtained after he or she has been given the opportunity to see what information is being forwarded and to indicate disagreement with any part of it.*
- (3) *That the recommendations relating to employee health information generally apply to information of this kind.*

The Board indicated that it also gives certain information to the Ministry of Labour:

Each month a copy of the updated computer master file tape of all first payment claims

is produced for the Ministry of Labour for its research branch. The file includes the ICD code and social insurance number but the employee's name is deleted.

At our hearings I was advised that in fact the social insurance number is also deleted. This information is also given to a safety association without the identifying data. The ICD code referred to is the International Classification of Diseases, adjusted for American purposes. The Ontario Health Insurance Plan also uses this classification. The Board uses a four-digit code; OHIP uses a three-digit code. The use of code was explained by R. W. Stephens, director of the Programme Planning and Statistical Services Branch:

...it is just a recognized international classification manual in terms of classifying diseases and injuries. Some other jurisdictions do use it too. There is a National Injuries and Statistics Program where the Board's injuries are concerned, co-ordinated by Stats Canada, that has been in existence for about five years. But as of today I think there's about three provinces, one of which is Ontario, participating and the purpose is to try and develop national statistics on industrial accident injuries, and every province has been told to use the ICD classification manual for reporting diagnoses.

In its submission, the Board said that it also supplies the Ministry:

...with a photocopy of every employer's initial report of a lost-time accident for the purposes of the Occupational Health and Safety Division.

The Division thinks that this information may make it aware of hazardous situations that may affect more than one person.

There is an information exchange between the Occupational Health and Safety Division of the Ministry of Labour and the Board. The Board may ask the Occupational Health Medical Services of the Occupational Health and Safety Division to visit a site to ascertain if a medical condition for which a workmen's compensation claim is being made is attributable to the

workplace. Dr. Pelmear, the chief physician of the Occupational Health Medical Services, said that, on such a visit,

...the field physicians don't usually examine personnel because they are inquiring primarily of the work situation of his complaint and his condition, and they rely primarily on the information from his family practitioner or the company physician as to the physical state of his health. But in process of seeing the individual, he may well superficially examine the skin condition which he is complaining of, and he may well have the chest x-rays and this sort of thing.

A report is made to the Board relating mainly to the environment in which the claimant is working but it may also discuss the claimant's condition. In some instances, Occupational Health Medical Services may have completed an investigation of a situation based on a report from other sources; this investigation is then referred to in the report to the Board.

There is a two-way flow of information between the Board and the Occupational Health Medical Services, as can be seen from the following exchange between Dr. Rodney May, Assistant Deputy Minister of Labour, and Mr. Strosberg:

MR. STROSBERG: Suppose that you have got reason to believe that you have a skin problem that relates to specific industries that may be important from an epidemiological point of view, to know, not current claims that may be under consideration, but those that the Workmen's Compensation Board may have dealt with over the last five years or ten years. What kind of access do you have to the files of people in specific industries?

DR. MAY: To date, when those questions have come up we have requested from the Workmen's Compensation Board just that type of information. We have identified this one place in this one plant, can you give us past claims history of that particular plant, that particular process.

MR. STROSBERG: And you say the request-- what kind of reply do you get?

DR. MAY: We get it.

MR. STROSBERG: You get it?

DR. MAY: Oh, yes.

The relationship between the two medical services departments was explained by Dr. G. DeBow, senior medical consultant of the Occupational Health Medical Services:

Let me explain a little bit about the relationship between the Compensation Board and the Occupational Health Medical Service. We act as consultants to the medical section of the Workmen's Compensation Board which deals with industrial diseases. The industrial disease section has physicians that deal with specific claims and they have an industrial disease section. The person that deals with most of our problems is Doctor Dorothy Burt. The name doesn't mean anything. There are other doctors that we deal with within the specific section of the Compensation Board.

Now these are the claims such as dermatitis, bronchitis, other things that deal with industrial diseases, and in order to facilitate the investigation of these claims there is a medical consultant who does go to the Compensation Board on a regular basis to review some of the claims with them. Then a memo comes to the, from the Compensation Board to our office asking us to investigate the claim. This is basically how it works and we would send a confidential report back to the Compensation Board for their information and adjudication.

No provision in The Workmen's Compensation Act allows this flow of information to a government Ministry, beneficial as that may be. Nor is there any authorization for providing the Ministry of Labour with a photocopy of every employer's initial report of a lost-time accident (form 6) for the purposes of the Occupational Health and Safety Division, as is now done, according to the Board's brief, despite the fact that the information

would be useful to the Occupational Health and Safety Division. Given the nature of the form used, however, it is not clear how helpful it is to the Division. The form does not contain a diagnosis of the disability; it is completed by the employer, not by a physician. The form asks the employer to, "State what the injury consisted of, the part of the body involved, and specify right or left side if applicable."

Although I believe that the exchange of information is of benefit to both the Board and the Occupational Health and Safety Division and should be expressly permitted, I am unable to make recommendations about the extent of the exchange and the nature of the information that should be exchanged. These are matters that the medical services departments of the Board and the Occupational Health and Safety Division should be able to agree upon.

Recommendations:

150. (1) *That The Workmen's Compensation Act and The Occupational Health and Safety Act, 1978 be amended to allow for an exchange, between the Medical Services Department of the Workmen's Compensation Board and the Occupational Health and Safety Division of the Ministry of Labour, of information that relates to the epidemiology of industrial diseases and of particular disabilities suffered by claimants.*
- (2) *That written guidelines relating to the extent of the exchange of information be prepared by the Workmen's Compensation Board and the Occupational Health and Safety Division.*
- (3) *That any information that is exchanged be subject to the provisions of the respective Acts prohibiting further disclosure.*

The Board also acknowledged that exceptions to the rule of non-disclosure do occur in subrogation claims:

Usually, with the Board's subrogation actions, proper medico-legal reports are obtained from the treating physicians. However, for small claims or where it is proper for preliminary information to be given to the defendant exceptions are made.

In subrogated actions, a certificate from the Board certifying medical aid payments is provided on request.

Under The Workmen's Compensation Act, where an employee suffers personal injury arising out of and in the course of the employment, he or she is entitled to compensation under the Act. Section 8 of the Act provides, in part:

(1) Where an accident arising out of and in the course of his employment happens to an employee under such circumstances as entitle him or his dependants to an action against some person other than his employer, the employee or his dependants, if entitled to benefits under this Part, may claim such benefits or may bring such action.

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(4) If the employee or his dependants elect to claim benefits under this Act,... the Board, if the compensation is payable out of the accident fund, are subrogated to all rights of the employee or his dependants in respect of the injury to the employee and may maintain an action in the name of the employee, or of the Board if the employer is in Schedule 1, or of the employer if he is in Schedule 2, against the person against whom the action lies...

In Else v. McCullagh (February 26, 1979), the claimant had elected to take compensation and the Board, in the exercise of its right of subrogation, brought an action in the name of the claimant for recovery of monies paid to the claimant. The Board refused to produce medical and hospital reports pursuant to section 52 of The Evidence Act on the ground of privilege under The Workmen's Compensation Act. It was held by Mr. Justice Montgomery that although the Board was not a party in name to the proceedings, it was a de facto party, that production of reports in the hands of the Board to defence counsel was for the

purpose of advancing the Board's subrogated action and should be produced. Again, in Atkins v. Iwanicki (1978), 22 O.R. (2d) 182, the Board was pursuing a subrogated claim for damages for personal injuries. It refused to produce medical records relating to the treatment of the injured party by the Hospital and Rehabilitation Centre to the defendant. It was held by Master Sandler that these records should be produced.

The attitude of the Board, in the instances cited, can be compared with its attitude in another subrogation case which we discovered in our examination of the files of the investigating firm of Canadian Claims Research (C.C.R.), whose activities are discussed in the section of the report dealing with W.A. King Ltd. and C.C.R. In one of the files the matter being investigated by C.C.R. on behalf of Shaw and Begg Limited (now Fireman's Fund Insurance Company of Canada) acting in the defendant's interest, was a claim in which the claimant had obtained compensation from the Board, which then brought an action for recovery of the money paid to the claimant. During the course of the investigation, Frank Oliva, the person assigned to the investigation, contacted someone at the Board and obtained medical information relating to the treatment of the claimant. When asked by Mr. Strosberg for an explanation of this, William A. Riddell, the solicitor and general counsel for the Board, in his written reply referred to "the importance of giving insurance adjusters sufficient medical information to set up sufficient reserves. It is also necessary to give sufficient medical information for the insurers to assess and evaluate the claim if any settlement is to be expected."

While I agree that it is necessary to give some information to insurers to facilitate a settlement of a claim, this should not allow confidential information about a claimant to be given to any person on behalf of the insurer. Care should be taken that such information is only given to a person with authority to make the settlement. I have dealt elsewhere with the argument that disclosure is justified because of the need of insurers to establish reserves and need not repeat what I have said, except to say that I do not accept the argument.

In his letter, Mr. Riddell added:

In summary, it is the Board's position that no medical information was given the defendant's representatives which would not have been properly compellable before trial...

If this were a justification, the activities of the private investigating firms would have been beyond criticism. I reject the proposition. Care must be taken by Board employees who deal with subrogation claims on behalf of the Board to see that confidential health information is given out only to the persons representing the defendant and not to all persons enquiring about the defendant.

Recommendation:

151. *That the subrogation department of the Workmen's Compensation Board refuse to provide any information to private investigators. The department should deal only with licensed insurance adjusters, insurance companies, or solicitors in attempts to settle its subrogated claims.*

In its submission the Board indicated that it also released medical information to certain government agencies and to insurance companies:

Where there are claims for benefits under the Canada Pension Plan or an insurance policy, the Board provides limited medical information to the organization. The same type of information is supplied to the Department of Veterans' Affairs.

The Board believes that the receipt by a claimant of the proceeds of an insurance policy may assist in his or her rehabilitation. In relation to the Canada Pension Plan, the Board explained that the information is provided to a staff physician pursuant to a suggestion made by letter in March, 1972, by the Honourable John Munro, then Minister of National Health and Welfare, that all physicians, including the medical staff of Boards and Commissions, co-operate in the furnishing of appropriate medical information in order to permit a determination to be made of eligibility for a pension. The Board provides medical information on production of a signed consent by the applicant for the pension. Where appropriate, photocopies or relevant medical documents are supplied along with a detailed medical résumé.

At the present time, the claimant cannot know what information is sent to the government agencies or to an insurance company pursuant to the authorization, since he or she is not allowed access to the medical record. A person, company or

other entity such as the Board, who is the holder of medical information about a person ought not to pass that information on to other parties unless the person to whom the information relates consents. That person, however, cannot give a true consent unless he or she knows what information will be forwarded, that is to say, what he or she is consenting to having transmitted. This is a recurring theme in this report and one that I think it important to emphasize. This proposition also applies to those disclosures of medical information which the Board makes to government agencies and insurance companies.

Recommendation:

152. *That before the Board releases any medical report it has in its possession to any person, agency or company to further a claim for a pension entitlement or for the payment of monies pursuant to an insurance policy by a claimant, it must have a consent for the release signed by the claimant. Before being asked to sign the consent the claimant must be given an opportunity to see the report or reports to be forwarded and have an opportunity to indicate what corrections he or she believes should be made. If corrections requested by the claimant are not made, the fact of the request should be noted on the medical records that are forwarded.*

According to the Board's brief, it also discloses information under other circumstances:

Under the Occupational Health and Safety Act, the Board is required to provide statistical data to local unions or employees, on request, concerning the accident records of the employer. No individual cases are identified and no medical information is provided.

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Information is supplied to the Unemployment Insurance Commission and to authorities operating under the Income Tax Act and under the Criminal Code. The usual case is where

there is a suspected fraud against the Board and against other public agencies.

These disclosures are not objectionable.

Pursuant to section 118 of The Workmen's Compensation Act (as amended by S.O. 1973, chapter 173, sections 1, 9(1) and (3), and S.O. 1975, chapter 47, section 15), compensation is payable to an employee who is disabled or dies from an industrial disease, or to his or her dependants. The categories of industrial diseases are not closed but are continually being assessed in the light of new evidence. Upon the acceptance of a new disease as being "peculiar to or characteristic of a particular industrial process, trade or occupation" (see section 1(1) of the Act), the Board considers that it has a responsibility to ascertain if there are cases of these industrial illnesses in which claims for compensation should be made. The Board endeavours to ascertain from employers the names of workers who are suffering from, or have died as a result of, the disease or condition. One employer received a letter from the Board in the following terms:

As you may already know the Workmen's Compensation Board of Ontario will now accept claims for specific types of cancer in workers exposed to asbestos.

Guidelines with respect to the adjudication of these claims have been established and we would like to meet with you to discuss this matter at your earliest convenience.

Would you kindly call me so that arrangements can be made to set up an appointment.

I would like to obtain from you a list of names and addresses of those workers known to you, who are suffering from or have died of lung cancer, mesothelioma, gastrointestinal cancer or laryngeal cancer.

This information can be supplied at the time of our meeting.

The Board assumes that the information requested is available to the employer either from the employer's medical department or from records of pension plans administered by the employer on behalf of the employees. The Board also requests unions to search membership records and supply information to it.

Upon receiving the letter quoted above, the employer refused to comply with the request on the grounds that the information was confidential and that any application for compensation should be made by the employee or his or her surviving dependants. The Board contends that the authority for requesting the information from the employer lies in section 117 of the Act:

(1) Every employer, within three days after he learns of the happening of an accident to an employee in his employment by which the employee is disabled from earning full wages or that necessitates medical aid, shall notify the Board in writing of,

- (a) the happening of the accident and the nature of it;
- (b) the time of its occurrence;
- (c) the name and address of the employee;
- (d) the place where the accident happened;
- (e) the name and address of the physician or surgeon, if any, by whom the employee was or is attended for the injury,

and shall in any case furnish such further details and particulars respecting any accident or claim to compensation as the Board may require.

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There is provision for a penalty in the event of non-compliance with subsection 1. There is no reason for an employer to refuse to co-operate with the Board's request in these circumstances; the notification of the acceptance of the industrial disease in this instance is equated by the Act with the occurrence of an accident which must be reported to the Board. Employers comply with this every day. If the recommendations in the discussion of employee health information are adopted, however, the employer would not have the information to give to the Board. The information would be held by the medical services department

of the employer, by physicians in the community, where there is no medical services department, or by the administrators of any pension plans and not by the employer. If the pension plans are administered by the employers on behalf of the employees, recommendation 131 prevents the information from being given to the employers without consent of the former employees or their estates or personal representatives. There is no authority in the Act for requesting the information from unions.

The Board already has the authority under section 52 of the Act to request the information from the company physician and from physicians within the community. The Board does not have the authority to request information from the company administering the pension plans on behalf of the employees. The Act should be amended, therefore, to give the Board such authority.

Recommendations:

153. (1) *That when new guidelines are formulated to acknowledge specific illnesses as being industrial illnesses, The Workmen's Compensation Act be amended to allow the Board to obtain from the companies administering the pension plans on behalf of the employees the names of those employees who are suffering from, or have died as a result of, the illnesses.*

(2) *That where an employer is the administrator of the pension plan on behalf of the employees, the information be obtained from the department or employee of the employer responsible for the administration of the plan.*

The Board uses a computer for information storage but not for the processing of claims. The complete system is not yet in place; it is being implemented in stages with the expectation that final completion will take place in 1982. It is anticipated that, once completed, the computer will provide assistance in the processing of claims. The system is being continuously reviewed during implementation, so that, as finally installed, the system may be different from that contemplated by the current plans. At present, there are no computer terminals outside the Board offices but the capability for them has been built into the system.

Elsewhere in this report I deal with many of the problems that the use of computers brings to the maintaining of confidentiality of health information and make recommendations which are intended to be minimum standards to which persons or organizations making use of computer systems should observe. I also endorse certain measures proposed by H. Dominic Covvey, my consultant in computer science, as minimum requirements without which a data base of almost any kind should not be considered secure. Those recommendations and requirements apply to the computer system used by the Board. This is not to suggest that I have any criticism of the system being introduced by the Board but simply to emphasize the importance of applying these recommendations and measures to every computer system. Nor do I intend to suggest that additional precautions should not be implemented. Special needs of users may require special precautions but all users should comply with the minimum standards recommended.

The Occupational Health and Safety Act, 1978

Today, it is essential in many industries, factories and work places that a constant watch be kept on the health of employees because of the many uses of biological, chemical or physical agents, or combinations thereof, in manufacturing processes. Medical examinations prior to commencing employment are common, and regular and periodic examinations are essential to monitor and detect the levels at which unsafe working conditions may be caused by the use of these substances. Workers and management alike are in agreement on the necessity of complete medical records, in order to monitor the health of individual workers in relation to known hazardous substances and also to provide a background for as yet unknown effects of existing and new substances introduced into the work place. The brief submitted by the Faculty of Health Sciences of McMaster University pointed out that a recent publication of the National Institute of Health stated that 20 per cent of all malignant diseases were attributable to occupational exposure to known carcinogenic agents. The brief continues:

Classic examples are the asbestos products industry, coke ovens, nickel refining and uranium mining where risks of particular cancers have been documented at between 10 and 1000 times that of the general population.

Workers may be exposed not only to carcinogenic agents but to other substances that are known to have deleterious effects on their health. The effects of excessive amounts of lead and mercury on the human body are well documented. Precautions are imposed on the handling and use of known hazardous substances in the work place but research is necessary to ensure that the effects of substances not as yet known to be hazardous are detected. As stated by the Science Council of Canada in its Report No. 28, Policies and Poison: The Containment of Long-term Hazards to Human Health in the Environment and in the Workplace, at pages 28 and 29:

The ways in which a risk is detected and appreciated are diverse. In some cases,

there may be a slow unfolding of medical and toxicological information on a world-wide basis, as for asbestos. The experimentation that led to the recognition that vinyl chloride in low concentration was likely to be a human carcinogen, on the other hand, was quickly followed by the detection of cases of a rare liver tumor attributable to it.

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It is clear that the more specific and the more readily identifiable the effect of a hazard, the quicker will be the recognition of the causal relationship. Had vinyl chloride produced a lung tumour indistinguishable from other lung tumours, we would probably still not be aware that it is a carcinogen. It is sobering to reflect that there may be other substances just as dangerous as vinyl chloride, but about which we are unaware precisely because the effects they produce are not specific.

Yet another dimension of the problem is shown by these statements. The harmful effects of a substance may be detected after only a short exposure to it or the effects may not be observed until after prolonged exposure. The effects of asbestos on the lung may be of such a general nature that detection of early signs or symptoms is difficult.

Mesothelioma (a fatal tumour of the lining of the lung) may occur from a low level of asbestos dust concentration over a relatively short period of time but may not become evident until many years after exposure. A short but high exposure to radiation is known to be harmful but the long term effects of low levels of radiation are still unknown.

There are three fundamental problems.

1. Exposure to a substance or process known to be hazardous with the result that the effects of the exposure will be detected in a relatively short span of time, as in the case of excessive amounts of lead in the blood.

2. Exposure to a substance known to be hazardous although the effects of the exposure may not be evident until many years later. Dr. Irving Selikoff, Professor of Medicine, Mount Sinai Hospital, City University of New York, in a speech which he

delivered to the Ontario New Democratic Party convention in 1976, gave the following example of a man who came to see him in 1951:

He had been a machinist and a truck driver. He had a normal x-ray and I patted him on the back and I said:

Bob, I find nothing. You're well. You're probably nervous - a condition that doctors call hyperventilation. You're going to be fine.

Now I have a pretty strong personality - so he believed me and did feel better. He went home. However, he came back in 1958 and now he had the scarring that you see on this x-ray on the lower part of the x-ray. And this kind of scarring is a dead ringer for asbestosis.

And I said:

Bob, you told me that you'd been a truck driver and a machinist. You'd never worked with any dust.

Well, his wife, who was sitting in the corner of the room said:

Bob, don't you remember in 1935 when we first got married you worked as a asbestos weaver.

"Oh, that"... he said ..."that was for six weeks."

And that's the point. He had only six weeks of exposure, but the dust he inhaled was in his lungs from that point on. So by 1958 his lungs had been exposed for 23 years. There was no turning back, once those six weeks had gone.

3. Exposure to a substance not yet known to be hazardous. In such a case, there are of course no data to indicate how the substance or process will affect persons subjected to either

long or short periods of exposure. This is the problem referred to in the last sentence of the quote from the report of the Science Council of Canada.

These problems may be complicated by the life style of the worker. For example, lead may be absorbed more quickly into the blood stream of a worker with a drinking problem; the aetiology of lung cancer, bronchitis or emphysema in a worker exposed to asbestos or other dust who also smokes may be obscured. The only way these hazards to the health of workers in the work place can be detected is by ensuring that records are kept, both to monitor the health of the workers on a periodic basis and to indicate the exposure of the workers to specific substances and processes.

The Occupational Health and Safety Act, 1978, S.O. 1978, chapter 83, which I will refer to as the Act, makes provision for these records to be maintained. The Act provides that employers establish and maintain occupational health services for workers as prescribed. Employers are required to keep and maintain accurate records of the exposure of workers to various toxic substances. A duty is imposed on workers to submit to such medical examinations, tests and x-rays as may be prescribed. Section 41(1) empowers the Lieutenant Governor in Council to "make such regulations as are advisable for the health and safety of persons in or about a workplace." The Act provides for the appointment of a health and safety representative in the case of a construction project at which the number of workers regularly exceeds twenty. The health and safety representative is to be selected by the workers from the non-managerial workers on the site. Where twenty or more workers are regularly employed at a work place (certain occupations, e.g., teachers, office workers, janitors, shop workers, librarians, and museum attendants are exempted), a joint health and safety committee must be established, which is to consist of at least two persons, of whom half shall be workers who exercise a non-managerial function and who are selected by the workers.

The function of the health and safety representative and the joint health and safety committee is to identify situations that may be a source of danger or hazard to workers and to make recommendations to the constructor, employer and the workers. The function of a health and safety representative is to make recommendations relating to the physical condition of the work place, but a joint health and safety committee has wider powers which include matters relating to the health of the workers. Using criteria set out in the Act, the Minister has authority to order that a health and safety representative or a joint health and safety committee be established at a work place or part

thereof that does not normally require a committee or representative to be established. The Act empowers the Lieutenant Governor in Council to prescribe any biological, chemical or physical agent or combination thereof as a designated substance and to regulate or prohibit the use of such substances. Under section 20, where a non-designated substance is used or intended to be used in a work place and, in the opinion of a Director (an inspector appointed as a Director of the Occupational Health and Safety Division of the Ministry of Labour), its use or presence is likely to endanger the health of a worker, the Director may order that its use be prohibited or limited or restricted in any manner and be subject to such conditions as the Director orders. Copies of these orders must be made available by the employer to the health and safety committee, health and safety representative and trade union, if any, as well as posted in a conspicuous place in the work place.

For the purpose of this report the important question is who should be allowed access to the records that will come into existence by reason of the legislation. Various persons and groups claim the right to be allowed access to protect the health of the worker. Employees claim a right to be able to see records relating to their own health and exposure to toxic substances. At the present time, such a right is not usually acknowledged, largely because of the attitude of the majority of the medical profession that it is not always in the best interest of patients to see their records. It is often asserted that the patient will not be able to understand the terminology used and may, in fact, be alarmed when there is no need for concern. Further discussion of this issue will be found in the section of this report devoted to the issue of access to one's own health information. It will be apparent from a reading of that section that it is my view that patients should be able to have access to their records, except in special circumstances. In the section on employee health information it is recommended that employees have access to health records that come into existence in the work place. This recommendation is equally applicable to the results of any biological testing or x-rays carried out or taken, whether the monitoring programme was established by the employer voluntarily or because of regulations made under the Act.

A more difficult problem is the extent to which employees should be entitled to know of health problems of other employees. This information may be desired for the purpose of detecting trends within the work place. For example, a worker who develops a skin rash may be concerned to know whether other employees developed the same skin rash. Symptoms of nausea or dizziness may fall into the same category. The causes of these

symptoms may be many but, if prevalent among many persons working at the same place, it may be reasonable to suggest a connection between the condition and the place of employment. The Act provides for notice to be given to fellow employees in certain circumstances. The employer is required to give notice to the joint health and safety committee, health and safety representative and trade union, if any, when a person is killed or critically injured from any cause at the work place, when, because of an accident, explosion or fire, a person requires medical attention and is unable to continue his or her work, or when an employer is advised that a worker has, or a former worker had, an occupational illness. The information required to be given includes the name and address of the worker who has, or had, the occupational illness or has been killed or injured, the nature and the circumstances of the occurrence and the bodily injury sustained, as well as the name and address of the physician or surgeon, if any, by whom the person was or is being attended for the injury or illness. Furthermore, the Regulations for Construction Projects (O. Reg. 659/79) provide that a notice must be given to the joint health and safety committee or health and safety representative and trade union when a worker becomes unconscious for any reason.

The brief submitted by the Occupational Health Nurses Association of Ontario expressed concern about the confidentiality of the information once it was in the hands of the trade union, joint health and safety committee or health and safety representative. The suggestion by the Association was that the potential recipients of health information pursuant to these provisions be provided with a copy of the Code of Practice for Safeguarding Health Information developed by the Canadian Health Record Association.

In those situations in which information is required to be given, the circumstances are normally such that, with some exceptions, the fact of the death or injury will be known to other workers. An accident that results in a death or critical injury to a worker is not likely to go unnoticed. Other injuries and illnesses, including occupational illnesses, may be less likely to come to the attention of fellow workers. The purpose of providing information, however, is to warn of a potential hazard. The fact is that it may sometimes be necessary for information to be imparted to others in an attempt to prevent a recurrence of the event. A notice of an occupational illness will alert others to watch for similar symptoms. While unions, health and safety representatives or members of a health and safety committee should be placed under a duty of confidentiality and should be given written guidelines relating to confidentiality, there must exist a discretion with respect to whether

the best course of action to be taken to prevent further industrial accidents or occupational illnesses is to advise others of the injuries and illnesses of fellow employees.

The notice referred to is limited in its scope. It alerts persons to danger to physical safety and to the fact that an occupational illness has been diagnosed. But, as it can take up to twenty years or more for some occupational illnesses to be detected, as in the case of disease resulting from exposure to asbestos, the notice does not permit an emerging trend to be observed. The right of workers to have access generally to health information of fellow workers is not otherwise stated in the Act. The health and safety representative is given the power by section 7 of the Act to inspect the physical condition of the work place and to identify dangerous or hazardous situations and to make recommendations or report his findings to the employer, the workers and the trade union. The functions of a joint health and safety committee, appointed pursuant to section 8, include the power to make recommendations regarding "procedures respecting the health or safety of workers". Unless the committee has access to information indicating whether, and in what way, the health of workers is being affected, it is difficult to see how it can effectively make recommendations relating to the health of the workers.

In the United States, the Occupational Safety and Health Administration (OSHA) proposed regulations that would provide that all employers keep and maintain accurate records of work related deaths, injuries and illnesses other than minor injuries requiring only first aid treatment. This "log" would be accessible to all employees, including former employees, and their representatives. OSHA envisaged that the type of entry placed in the log would not include elaborate details but would contain such entries as "dermatitis--arms," and "amputation--left forefinger." At hearings held by OSHA on the proposed regulation, the representatives of employers argued that this was an invasion of privacy rights of workers. The union representatives were unanimously in favour of the regulation. In the words of one union representative, "Worrying about confidentiality will only guarantee continuation of the contaminated work place." At hearings held by the American Privacy Protection Study Commission, Sheldon Samuels, director of the Health and Safety Industrial Union Department of the AFL-CIO, declared, "Privacy doesn't count, saving lives counts."

Although confidentiality ought not to be entirely discarded, there should be some mechanism available to workers to ensure a healthy work environment and to be able to detect trends suggesting that the work environment is potentially

dangerous. It is not necessary that all workers have access to the health records of other workers. The joint health and safety committees should be entitled to monitor the results of biological testing done on fellow workers. The committee should also have access to health records relating to work related injuries. This could be done by separating the health records of a worker into personal health records and work related records, the latter being records made as a result of injuries or complaints occurring or arising within the work environment. While there may be some blurring of the distinguishing lines between the two types of records, personal information, for example, to borrow an illustration, that a worker had undergone a sex change operation, would not be available for inspection by this method. What should be included in the record that is available to the committee are dates of visits to the occupational health service, if any, with a short indication of the reasons for the visit, together with results of x-rays and laboratory tests.

The Advisory Council on Occupational Health and Occupational Safety, established by section 10 of the Act, in its "Report on Confidentiality of Information", included as one of its recommendations,

That, where government mandated biological monitoring is conducted within industry by government or industry, the results of the tests should be available to management and labour in a form to assist preventive efforts.

Allowing the results of testing to be monitored by the joint health and safety committee, composed of representatives of both management and labour, is one way of carrying out this intention.

The access of the health and safety representative should be limited to the record that contains dates of visits to the occupational health service with a short indication of the reasons for the visit. The reason for a difference in access as between the health and safety representative and the joint health and safety committee is, first, that the function of the health and safety representative is only to make recommendations to the employer and the workers relating to the physical safety of the workers, and second, that the health and safety representative represents workers at a construction site where there is less likelihood that workers will be in contact with toxic substances.

One of the fundamental principles endorsed by this report is that health information should not be released to others without the informed consent of the person to whom the information relates. In certain circumstances, however, it must be recognized that this ideal is not always appropriate. Society accepts the mandatory reporting of specified illnesses in circumstances in which that information is necessary to protect the health and well-being of others or of society as a whole. Reporting provisions of legislation such as The Public Health Act, R.S.O. 1970, chapter 377, The Child Welfare Act, 1978, S.O. 1978, chapter 85, and The Highway Traffic Act, R.S.O. 1970, chapter 202, are a reflection of this recognition. Other legislation allowing for the reporting of certain events, such as births and deaths, is based on the premise that government has the right to obtain certain information in order to plan for the welfare of the population as a whole. Permitting some persons in the work place to see certain health information relating to others falls within both these exceptions to the general principle. Although occupational illnesses are not usually contagious in the same sense that measles and mumps are, knowing that certain symptoms or ill effects are being suffered by more than one person may be just as essential to protect the health of others in the work place as knowledge of those contagious diseases.

Experience shows that, where workers fear that the work environment is affecting their health, they are prepared to tell others of their health problems. This gives rise to a need for someone to be the official recipient of this information. Unless workers are aware that others are suffering the same ill effects, the symptoms could be dismissed as those of one person only. In some situations unions are the recipients of the employees' health information. Not all work places are organized, however, and, where there is no union, the joint health and safety committee or the health and safety representative seems to be the logical choice.

It is not only the health of fellow workers that may be protected in this way. Knowledge of the effects of toxic substances in the work place may alert one to the harmful effects of those substances on the population in general. As stated by Professor Alan Westin in his paper, OSHA Surveillance and Privacy, delivered at the First National Seminar on Individual Rights in the Corporation, the proceedings of which were published by The Civil Liberties Review:

Recent studies are equally clear in showing that various agents and processes used in productive facilities can have serious

effects on the health of nearby communities and their populations. Substances placed in air and water supplies, radiation levels given off, and similar activities originating in the workplace can have especially grave effects as long-term, cumulatively-dangerous additions to factors already present in geographic areas where productive facilities are located. Findings as to the effects of various agents and processes on persons exposed to them intensively as workers often serve as early warning signals as to the possible effects of these substances on the general population who are exposed to them in products. The workplace thus serves as a laboratory setting for signs of danger in thousands of chemical agents that will be used in our consumer society.

Persons who are given access must exercise extreme caution in using the information they may acquire. The consent of the persons whose health information will be used must be obtained before the information can be shown to others, including the employer. Common sense and experience indicate that this consent will not usually be withheld. If the consent of the person to whom the notice relates cannot be obtained because of the death or illness of that person, or because the person is no longer employed by the employer, there should be a discretion to release the information if the committee or representative is of the opinion that the health of workers in general is being adversely affected by conditions in the work place.

The Act includes a provision designed to protect the confidentiality of health information generated by the legislation. Section 34(1)(d) reads as follows:

Except for the purposes of this Act and the regulations or as required by law,

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- (d) no person shall disclose any information obtained in any medical examination, test or x-ray of a worker made or taken under this Act except in a form calculated to prevent the information from being identified

with a particular person or case.

In my opinion, the recommendations that follow do not conflict with this provision. The disclosures permitted fall within the language, "for the purposes of this Act and the regulations", which surely is the protection of the health and safety of persons in the work environment.

Recommendations:

154. That the right of the employees to have access to all their health records generated or maintained within the work place include the right to have access to the results of all biological or other testing required to be done on them.
155. That a worker be advised immediately if the presence of any abnormal or unusual condition is detected by a periodic examination, or by the results of laboratory testing or x-rays, whether work related or not.
156. (1) That, where the employer maintains an occupational health service, a record be kept which shows the dates of visits with an indication of the reason for the visits.

(2) That the joint health and safety committee and the health and safety representative have a right of access to this record.
157. That the joint health and safety committee be allowed access to the results from biological monitoring of employees required by The Occupational Health and Safety Act, 1978.
158. That the joint health and safety committee or health and safety representative be placed under a duty of confidentiality and be provided with guidelines prepared by the Ministry of Labour in consultation with the

Ministry of Health relating to confidentiality of health information generally.

159. (1) That the joint health and safety committee or health and safety representative may not disclose information concerning the health of an employee to the employer or to other employees without the consent of the worker to whom the information relates.

(2) That where the consent of the worker to whom the information relates cannot be obtained because of the death or illness of that person, or because the person is no longer employed by the employer, there be a discretion to release the information if the committee or representative is of the opinion that the health of workers in general is being adversely affected by hazardous conditions in the work place.

160. That, where a trade union receives information under sections 25, 26 and 27 of The Occupational Health Act, 1978, recommendations 158 and 159 above apply to that information in the hands of the trade union.

The Act also empowers the Minister to require by regulation that sampling, analyses, examinations and tests be carried out and performed by approved laboratories. The brief submitted by the Occupational Health and Safety Division indicated that the Occupational Health Laboratory analyses specimens submitted by company physicians in charge of medical surveillance programmes. Specimens may also be submitted for analysis on the request of the physicians in the Occupational Health Medical Services Division, workers' physicians, workers and employers. It is not clear who receives the result of the analyses when the samples are submitted by the employer. After analysis, the results are recorded in a report. One copy is forwarded to the physician requesting the testing, one copy is retained in the laboratory and another is sent to the Chief of the Medical Services. At our hearings, I was advised by Dr. P. Pelmear, of the

Occupational Health Medical Services of the Occupational Health and Safety Division of the Ministry of Labour, that it is envisaged that in the future when specimens are collected the individual concerned will be asked to nominate a physician to whom the results would also be directed. The brief also indicated that the Industrial Chest Disease Service, which functions under the Ministry of Labour and is concerned with the surveillance of workers in work places in which occupational respiratory conditions can occur, visits these work places on either a one-year or two-year cycle to take x-rays and carry out lung-function testing. A report is compiled which lists all employees alphabetically with complete results of x-rays and lung-function tests. A copy is given to the company physician and to the local medical officer of health. It is not easy to appreciate why x-ray results are sent to the medical officer of health rather than to the Occupational Medical Services Division. It seems to me preferable for the Division to obtain results from both testing units. Unless any abnormality is detected that would require reporting under the provisions of The Public Health Act, copies of testing results from the Occupational Health Laboratories, the Industrial Chest Disease Service, and any other unit authorized under the Act to conduct testing should be forwarded to the Chief of the Occupational Medical Services Division.

Where there is no company physician, the Industrial Chest Disease Service forwards results to the local medical officer of health and to the workers' family physicians. The Division's brief said that at present, where there is a company physician, results of testing are not sent automatically to the family physicians of workers, except where the worker has been exposed to asbestos. Where a worker has not given the name of a family physician he or she is notified directly by letter that abnormal shadows or abnormal lung function have been discovered and is requested to provide the name and address of a physician to whom the results may be forwarded. There is an intention that eventually all workers tested by the Industrial Chest Disease Programmes will be asked to nominate a physician to whom the result of the testing will be sent. Again, it is not clear why the local medical officer of health should be advised of test results if the worker has nominated a physician to whom the results should be sent. It is reasonable that the local medical officer of health should be notified in a case in which an abnormality is detected and the worker has not nominated a physician to whom the results should be forwarded. In these circumstances, the local medical officer of health has both the staff and the resources to ascertain whether the worker seeks treatment for the suspected abnormality.

The local medical officer of health is also notified when it is suspected that family members of workers may also be at risk because of the work environment. This risk factor has been documented with families of asbestos workers through whose clothing the asbestos fibres are brought into the home, causing a family member to contract mesothelioma. Other potential problems may be less direct. As stated by Professor Westin in the paper cited earlier,

The health of worker families has been shown to be affected both directly (through transmission of health problems to offspring) and through the creation of problems such as impotence, sterility, and abortive births that are both serious in themselves and of strong psychological impact on family mental health. Conservative estimates by industry groups show that almost half the total work force is subject to the types of occupational conditions that can produce such effects on worker and executive health.

That this has been recognized for some time is suggested by the fact that the form required to be completed by the mother or father of a stillborn child requires information concerning the occupation of both parents. Form 7, "Statement of Stillbirth" of Regulation 820, made under The Vital Statistics Act, R.S.O. 1970, chapter 483, includes the following question in the section headed, "Particulars of Husband":

11. Q (1) Trade, Profession or
C Kind of Work
U (see note 3)
P
A
T
I
O
N (2) Type of Industry
or Business
(see note 4)

Notes 3 and 4 read:

3. Under item 11(1) the trade, profession or kind of work in which the husband or father is occupied is to be inserted, for example: spinner, doctor, office clerk, sales clerk, salesman, labourer, et cetera.

4. Under item 11(2) the type of industry or business in which the husband or father is occupied is to be inserted, for example:

paper, lumber, coal, newspaper, insurance,
banking, clothing, grocery store, et cetera.

Question 19 on the Form asks the same question as question 11 concerning the mother. The accompanying notes to question 19 indicate that if the mother is a housewife the answers are "housewife" and "at home" respectively.

The practice of the Occupational Health and Safety Division, in situations in which it is feared that family members may be at risk, is so to advise the local medical officer of health. Dr. Rodney May, then Assistant Deputy Minister of Labour, Occupational Health and Safety Division, explained the reasoning at our hearings:

As we clearly established many years ago in South Africa the relationship to asbestos workers where the family had a high incidence of mesothelioma of the lungs higher than the incidence among the actual workers themselves. It has also been established in relation to other occupational hazards. Beryllium, for instance, the incidence of beryllium disease in some families in one particular part of the States was much higher than amongst the workers themselves. Obviously when it has been identified that there is a considerable risk to an individual we don't completely chop off the rest of the community. Our interest is in this one particular occupational segment, but we also have to take into account other community exposures, and logically one would pursue this. This is what has happened in terms of one particular group whereby notification goes to the medical officer of health as a result of x-ray findings.

Now he then is in the ideal position to take this up with the family physician. Very often the physician of the worker is not the same as the physician to the family, so it has been done in the context that once the problem has been identified, the risk has been assessed, the possibility that this risk might pass on to other people, then this is done in this particular instance in relation to the medical officer of health.

Although the situations in respect of which the local medical officer of health is notified are not set out in either The Public Health Act or The Occupational Health and Safety Act, 1978, it does not follow that notice in all cases ought to be discontinued. The type of health risks involved may quite reasonably be termed public health risks, not unlike communicable diseases, except that the aetiology of the illnesses differs.

Recommendations:

161. *That the present practice of advising the local medical officer of health of an abnormality in an employee detected by testing pursuant to The Occupational Health and Safety Act, 1978 be authorized by an amendment to The Public Health Act or The Occupational Health and Safety Act, 1978.*
162. *That notice to the local medical officer of health be given when*
 - (a) an abnormality is detected in a worker and there is no company or family physician to whom the report may be sent; or*
 - (b) because of the work environment there may be a health risk to family members of the worker.*

Employers also contend that they should be allowed to see the health records of workers to enable them to monitor conditions in the work place and to ensure that, if a worker's health is being affected by an exposure to a dangerous substance, those in authority will be aware of this at an early stage and be in a position to remove the worker from the area of exposure by transferring him or her to another area. The Section on Occupational Health of the Ontario Medical Association supports the contention that it is necessary for some medical information to be given to the employer, "so that appropriate control measures may be taken." The Section referred with approval to the OSHA standards for asbestos and benzene, which allow results of specific testing carried out on an employee to be given to the employer. The practice in some of the other provinces, for example British Columbia, is to allow the results of the testing for levels of exposure of workers to specific substances to be sent directly to the employer.

The approach of the Occupational Health and Safety Division of the Ontario Ministry of Labour, as indicated in its brief and by representatives appearing at our hearings, is that identifiable results of biological testing or x-rays should not be given directly to the employer but should be sent to the company physician or other physician requesting the testing. In fact, the brief indicated that, at the present time, the Occupational Health Laboratory will not send results to an occupational health nurse who may request them. The nurse will only be advised whether or not there is cause for concern. If it is necessary to remove a worker from an area of exposure, the nurse is advised to confer immediately with the physician in charge of the medical surveillance programme. A memorandum dated November 30, 1978, from Dr. Ann E. Robinson, Chief of the Occupational Health Laboratory, emphasizes the confidentiality of results of testing all clinical specimens and directs that reports of results are to be sent to the referring physician only:

RE: Analytical Results for Clinical
Specimens

It is essential for all members of the Occupational Health Laboratory staff to appreciate that all results of analysis of clinical specimens are CONFIDENTIAL and to ensure that reports etc. are treated accordingly.

The following basic rules apply:

- (1) reports of results are to be addressed and mailed to the referring physician with a copy to the Occupational Health Branch Chief of Medical Services.
- (2) verbal reporting of results may NOT be made without my prior knowledge and consent.

I recognize that there are occasions when it is necessary to report verbally. For example a) when there is a specific request on behalf of a company or b) because some results may indicate a need for clinical intervention or c) there is an interruption of postal services.

In such instances, verbal reports will be made to the referring physician either by me or a Senior Scientist (preferably after consultation).

Please advise me immediately if you encounter any particular problems or difficulties.

The Industrial Chest Disease Service provides management with a summary of the results indicating the number of examinations with a breakdown of the number of abnormal results, for example, occupational lung diseases and cancers, but names of workers are not provided except in cases of suspected tuberculosis. According to the brief, because disclosure of names of workers is not required by The Public Health Act, consideration is being given to discontinuing this practice. I think that it should be stopped at the earliest opportunity.

Employees favour monitoring for occupational hazards but are often suspicious of the motives of the employer. For example, Ed Hunt, the Health and Safety Representative of the United Electrical Radio and Machine Workers of America, wrote to me as follows:

In conclusion, we feel that workers do have to have their health continuously monitored by independent medical means, as we attempt to identify the many thousands of dangerous substances we work with every day. But we certainly believe that the confidentiality of this monitoring is the employee's right to his or her good health, and not for any other reason that the employer may endeavour to use the information.

The brief submitted by the United Steelworkers of America, Local 1005, contains these statements:

The value of the health assessment lies in that it serves as a basis for determining the fitness of the candidate to carry out specific duties; serves as a reference point for any subsequent changes arising out of the hazards of the work or workplace; documents history of exposure to toxic hazards and substances; and assists in the placement of individuals with diagnosed disabilities in occupations compatible with the disabilities.

Some people feel that the health assessment is to exclude persons from work. This should not be so. The assessment should be kept confidential and the medical department only informs management as to the suitability of the job placement. Because of past practices within industry, if people feel that the medical may hinder them from obtaining a job, they will then hold back pertinent information.

Employees appear to be suspicious that employers will use the results of monitoring to dismiss workers who show signs of being affected by the work environment, or because of the results, move an affected worker to a position that carries decreased benefits. Another aspect of the problem is the concern that, if records are kept of exposure to specific substances, regulations may provide, or employers may decide, that a worker with a history of exposure to a particular substance is not suitable for a job that will subject him or her to further exposure.

The United States Privacy Protection Study Commission referred to these problems in its report, Personal Privacy in an Information Society, and made the following recommendation:

That Congress direct the Department of Labour to review the extent to which medical records made to protect individuals exposed to hazardous environments or substances in the workplace are or may come to be used to discriminate against them in employment. This review should include an examination of the feasibility of:

.

- (b) establishing mechanisms to protect employees whose health has been affected by exposure to hazardous environments or substances from the economic consequences of employers' decisions concerning their employability.

Although my terms of reference do not permit me to make a similar recommendation, I venture to suggest that some thought be given to establishing such mechanisms.

During the discussion of the question of workers' access to their health records, Dr. May made this comment:

...It's nice to have that information. It's what you do with it and how you interpret it. This is one of the reasons for not giving the individual employee the raw data and just leaving it at that. You need an interpretation.

And in the brief submitted by the Occupational Health and Safety Division it was stated:

Test results are not sent directly to workers since personal factors unrelated to occupational exposure may have to be taken into account in order to ensure a proper interpretation.

The same observations about the need for interpretation of the data as they relate to the individual can be made with respect to the employer's receipt of the test results. The results in the hands of the employer, without medical advice about the meaning of those results, is of little use. The company physician or other physician ordering the tests should interpret the results for the employer and advise it of any need to transfer a worker from a particular exposure to another area of the work place. I recommend that results of testing should continue to be sent to the physician requesting the test but non-health personnel of the employer should not be permitted to open the reports.

It does not follow that because workers are given results of their tests employers should also have them. The interests of workers, on the one hand and of employers, on the other, are different. Some of these differences have been cogently stated by Professor T. Ison in a passage which I have set out in the section on the Workmen's Compensation Board and which is equally relevant to this discussion. Workers should have a right to know everything that relates to their health. Employers are entitled to know about the fitness of a worker for a particular job. Less frequently the employer will want, and should have the right to, facts relevant to the question whether additional safety precautions should be implemented, the answer to which involves a consideration of the economic feasibility of the precautions. Requirement of knowledge of an employee's fitness can be satisfied by allowing the plant physician to interpret the tests results and give his opinion to the employer. The need

for information relating to safety precautions can be satisfied by allowing access to the results of any testing to the joint health and safety committee, which represents the interests of both employer and workers. Any trend that workers' health in general is being adversely affected by conditions at the work place should be detected by the joint health and safety committee which can then seek the consent of the employees affected to discuss the issue with the employer. There is good evidence that consent will rarely be withheld in these circumstances.

Recommendations:

163. (1) *That the results of testing of workers for exposure to occupational hazards be sent to the requesting physician and not to the employer.*

(2) *That the physician interpret the results and advise the employer whether a given worker is fit to continue in the same job and whether any modifications of the employment should be effected.*

(3) *That the employer may receive a summary of results with a breakdown of the number of abnormalities found among the workers, provided that identifiable information is not included in the summary.*

164. *That the Industrial Chest Disease Service discontinue the practice of disclosing to employers the names of workers suspected of having contracted tuberculosis.*

I have already expressed the view that it is sometimes necessary for the government to be the recipient of certain health information in order for it to fulfil its responsibilities to society as a whole. This raises the question of the extent to which government should have access to health records generated in the work place. Government's recognition of its rightful role in protecting the health of workers is manifested by the existence of the Act and the power that it gives to require the monitoring and control of exposure of workers to hazardous substances, and to provide that proper medical surveillance

programmes are carried out. It is necessary for the Occupational Health and Safety Division of the Ministry of Labour to be alerted to potential danger in the work place to enable procedures to be put into place to protect the health and safety of workers. This can be done by requiring that concerns that substances are affecting the health of workers be directed to the Occupational Health and Safety Division, which can then investigate the matter further. It can also be done by having the Occupational Health and Safety Division make constant checks on the work place so that it can become directly aware of potential problems.

Whatever method is chosen, one aspect of the investigation must be by way of access to health records of the workers exposed to the suspected hazardous substances. It might be thought that this can be effected by providing for access to OHIP records. However, the point was made at our hearings that these records are not considered useful for this purpose:

DR. MAY: Well, the point is that there would be nothing to be gained in terms of his occupational history from the OHIP records. And if we are going to investigate hazards to the health of the worker in terms of his occupation, we need to have both his current history in relation to how long he has worked in this particular place, what other places he has worked at in the past, and you do not find this on OHIP records.

Records of family physicians are also thought to be not useful as a starting point to trace occupational illness since most records kept by the family physicians do not contain occupational history. Our investigation disclosed that, in the United States, the National Institute for Occupational Safety and Health takes the view that it is more of an invasion of a worker's privacy for that agency to receive records from the worker's family physician than from the employer. Records held by the employer chiefly relate to occupationally related diseases; the family physician's record deals with all treatments, including family treatment. In investigating the health of a particular worker or group of workers, information may often be sought from the workers' physicians but the starting place is usually those records that come into existence in the work place itself.

Section 41, subsection (2)11. of the Act empowers the Lieutenant Governor in Council to make regulations,

respecting the reporting by physicians and others of workers affected by any biological, chemical or physical agents or combination thereof;

The Act also allows for inspection of health records generated in the work place. Section 28, subsection (1)(c) provides that:

An inspector may, for the purposes of carrying out his duties and powers under this Act and the regulations,

.

- (c) require the production of any drawings, specifications, licence, document, record or report, and inspect, examine and copy the same;

I have been told by the Occupational Health and Safety Division that it is intended that only inspectors who are physicians will be authorized to examine medical records pursuant to this provision. I accept the need of government inspectors to be able to see records without requiring prior consent of the workers, whether investigating a complaint that a substance used at a work place is affecting the health of workers or ensuring that employers and employees are complying with duties established under the Act or regulations. Workers, however, must be assured that those examining health records will be aware of the need for confidentiality and competent to understand the implications that the records may contain for the health of the workers. By restricting the right to examine the records to physicians, both of these requirements should be met.

There are, however, other concerns to be considered. In December, 1978, the U.S. Occupational Safety and Health Administration published, in the Occupational Safety and Health Reporter, guidelines relating to access by government officials which were being considered by that agency:

OSHA should seek to examine or copy identifiable records containing medical (or similarly personal) information, or trade secret/confidential business information, only when it has a demonstrable need for such information which cannot be satisfied

by less intrusive means (e.g., removal of identifiers or personal interviews).

A system of approving access to such records should be established so that a request to seek access requires an affirmative decision at a fairly high level of authority within the agency that such access is necessary to accomplish a statutory purpose, and so that it is clear as to who within the agency may be held accountable for making the key decisions concerning records access.

Access to these records should be strictly limited to those employees and contractors (including support staff) who have both the qualifications and the need to examine such confidential and private information.

Even though OSHA access to these records should not be conditioned on the consent of the employee who is the subject of the record, the affected individual should nevertheless, to the extent possible, be notified that the agency seeks access to his or her record, so that the individual may be aware of the purposes for which the records are sought and may have a reasonable opportunity before the agency places a copy of the record in its files to raise objections to the agency or seek other legal recourse.

A system of control over, and physical security of, these records when in the physical possession of the agency should be established to assure that their integrity is maintained and that they are completely unavailable to unauthorized persons.

Personal identifiers should be removed and destroyed as soon as they are no longer needed for the purposes for which they were originally sought.

Requests for interagency sharing of information should be carefully scrutinized at the highest level of the agency to uphold the principle of "functional separation" (i.e. voluntary release of information only

for general safety and health--and not law enforcement of individual determinations--purposes).

Requests for public disclosures of information to a private person should be carefully scrutinized so that no information which may be properly withheld from disclosure under the Freedom of Information Act or the Privacy Act is in fact disclosed.

I agree with the premises underlying these guidelines. They are that access should not be sought without consideration of its importance and that, once access has been had and copies obtained, care must be taken to ensure that the information is not available to unauthorized persons.

With respect to the first of these premises, it is highly desirable that the Occupational Health and Safety Division of the Ministry of Labour issue guidelines indicating in what circumstances and pursuant to what authority access to the health records will be sought and the records copied. Notice should be given to the workers concerned when access is sought so that they may be aware of the purposes for which the access is sought but I see no need to establish a right in the workers to take action to prevent access to their own records. If the Occupational Health and Safety Division decides, after due deliberation, either because of a complaint that the health of workers at a work site is in jeopardy or for some other reason, that access is necessary to protect the health and safety of the workers at that work site or of workers in general, then such access should not be prevented. Once the Division acquires copies of health records, then, as proposed by the American Administration:

A system of control over, and physical security of, these records when in the physical possession of the agency should be established to assure that their integrity is maintained and that they are completely unavailable to unauthorized persons.

Individuals whose records are copied and maintained by the Occupational Health and Safety Division should be advised of the controls used to ensure that the confidentiality of the records will be maintained. Access to the records in the possession of the Division should be strictly limited to those employees, including support staff, who have both the qualifications and the need to examine them.

In the section on the Workmen's Compensation Board there will be found a discussion of the exchange of information that now occurs between the Occupational Health and Safety Division and the Board. There a recommendation is made that, where the exchange relates to the epidemiology of industrial diseases and of particular disabilities suffered by workmen's compensation claimants, the exchange be authorized, subject to the preparation of written guidelines by the medical services departments of these bodies. Requests for an exchange of identifiable health information with other government departments should be subject to similar guidelines. It is desirable that these guidelines be available to the public upon request so that workers, that is, those whose records could be the subject of these exchanges, may be aware of when and in what circumstances the exchanges are permitted.

Recommendations:

165. *That only inspectors who are physicians working within the Ministry of Labour be allowed to inspect health records in the work place.*
166.
 - (1) *That the Occupational Health and Safety Division of the Ministry of Labour issue guidelines setting out in what circumstances access to health records in the work place will be sought and the record copied.*
 - (2) *That access to these health records by the Division not be conditional upon the consent of the employees who are the subjects of the records, provided the guidelines referred to above are followed.*
 - (3) *That the employees to whose records access will be sought be given notice setting out the purpose for which access to the records is sought.*
167. *That a system of control and physical security of the records in the physical possession of the Occupational*

Health and Safety Division be established to ensure that their integrity is maintained and that they are unavailable to unauthorized persons.

- 168. That written guidelines be prepared indicating when and in what circumstances any sharing of identifiable employment health information with other government departments or agencies might be permitted.*

A significant question relating to health records generated in the work place is that of their availability to researchers. The importance of research to occupational health and safety cannot be overstated. Many substances and processes now used in the work place will need to be studied to ensure that any harmful effects on the health of workers may be detected as soon as possible. The brief submitted on behalf of the Faculty of Health Sciences of McMaster University described the nature of much of the research in the occupational health field:

Virtually all of the currently known occupational risks have been identified using a retrospective research design in which an historical group of workers in any industry is tracked forward in time to the present day to identify the mortality experience of the group. Rates of mortality due to each cause are calculated for various occupational groups within the industry, or by various levels of cumulative exposure to some suspicious contaminant, and compared to what would be expected in a similar but unexposed group.

This design is clearly based on two pre-existing sources of information. Firstly, industrial records suitable to define the work force at some point in time and to document their occupational exposures. Secondly, mortality information including the date and cause of death. While the industry can often provide some limited mortality information about its workers (through pension and insurance records), most studies rely on access to official death registration information for complete

mortality ascertainment. It is this feature which makes epidemiological research in Occupational Health dependent on continued access to confidential records.

In its "Report on Confidentiality of Information", the Advisory Council on Occupational Health and Occupational Safety listed the principal sources of information relevant to occupational health and safety and added a description of these sources:

- (1) The Office of the Registrar General of Ontario;
- (2) Statistics Canada;
- (3) Ontario Workmen's Compensation Board;
- (4) Occupational Health and Safety Division of The Ministry of Labour;
- (5) Ontario Ministry of Health;
- (6) The Hospital Medical Records Institute (HMRI)
- (7) Ontario Ministry of the Environment;
- (8) Records within industry; and
- (9) Family physicians and hospitals.

The best description of the information pool for occupational health and safety is that it is decentralized at the present moment. The vital statistics are stored within the provincial and federal statistical machinery. The Ministry of Health has records which provide information about the health history of individuals within the province. This source is of limited value because of the lack of personal identifiers in the medical record system. The Ministry of Labour has information about some aspects of occupational health and safety in relation to industry and individuals and levels of exposure. The Workmen's Compensation Board has substantial data about both industry and individual workers. Industry will have variable records about its staff as well as detailed information about the actual jobs and processes involved. Finally, family physicians and hospitals have records about individuals in relation to their health problems.

Although my main concern relates to health records that will come into existence because of the Act and regulations, my comments are equally applicable to other records containing health information which are held by other government departments.

As I have already pointed out, many of the effects of substances used in the work place are unknown. It is only by careful and patient research that any deleterious effects can be discovered. Researchers will not always be able to obtain patient consent to using identifiable health information because subjects may have died, may have moved elsewhere or cannot be located. Every research project must be assessed separately. One criterion by which the assessment is made must be whether the research proposed is important enough to justify the invasion of privacy.

Because of the importance I attach to research in this field, it is my view that the branch of the Ministry responsible for monitoring the health of the employees should be prepared to allow access to records held by it to research projects which have been approved by the appropriate human experimentation committee as being valid and as having efficient safeguards to protect the confidentiality of the material being used. In addition to ensuring compliance with the Act and regulations, a principal purpose of collecting records should be to preserve them for research. If they are not made available for research there would be little justification in keeping them for any longer period than that necessary to demonstrate compliance with the legislation. As Dr. Fraser Mustard, Dean of the Faculty of Health Sciences of McMaster University, pointed out at our hearings:

What right does the public service have to acquire information about me, say the place in which I work, and not ensure that that information is available for legitimate studies that concern the overall welfare of the population.

This, of course, applies not only to information collected by the Occupational Health and Safety Division, but also to such other government departments or agencies that collect health information about persons in the workplace as the Workmen's Compensation Board. For this reason I do not think that personal identifiers should be removed from the records unless a code is substituted, so that they can be recalled if necessary. I have in mind the type of retrospective research that was referred to in the brief submitted on behalf of the Faculty of

Health Sciences of McMaster University and for which personal identifiers, such as name and birth date, are essential.

Recommendations:

169. *That use of the Ministry of Labour's identifiable occupational health information be subject to recommendation 94 relating to research.*
170. *That a record accessible to the public be kept of all persons or groups requesting access to the Ministry of Labour's identifiable occupational health information for research purposes and of whether such access has or has not been granted.*

If this condition is complied with, there should be no refusal to co-operate with the researcher by the Ministry on the basis of a concern for the confidentiality of the records in its possession.

APPENDIX I

Common Law Remedies for Disclosure of Confidential Medical Information

A Study Prepared for the Royal Commission of Inquiry into the Confidentiality of Health Records in Ontario by Professor S. Rodgers-Magnet, Faculty of Common Law, University of Ottawa, 1978.

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Introduction:

Existing common law provides several varying remedies for the unwarranted or abusive disclosure of confidential medical information. These remedies are to be found in the various doctrines of contract and tort, in statute and in actions based on breach of statute. Nonetheless, few actions alleging unwarranted disclosure of medical information have been brought and, despite a case history dating back to at least 1776, any study of the availability of a right action for disclosure must conclude that, with regard to the most fruitful of the legal theories upon which such actions may be based, the availability of recourse depends on pushing the legal basis of the action to its outer limit. Furthermore, given the minuscule number of such actions brought in common law jurisdictions, including that of the United States, any study of the remedies available for disclosure of confidential information, must give consideration to the real efficacy of remedies so rarely enforced, particularly in the light of clear evidence concerning the level of abuse if not the level of damage. In Part I, this study will examine the existing remedies available to the person who alleges that medical information concerning himself has been released to another. In Part II, consideration will be given to the necessity of further protection, to the various existing proposals for reform and to recommendations for appropriate methods to protect the confidentiality of medical records.

The earliest actions alleging unwarranted disclosure of personal medical information not only illustrate the uses to which such personal information can be put and the conflicting social values thereby engaged, but also the varying bases upon which such allegations continue to be made.

The seminal decision is that of the House of Lords in the trial of Elizabeth Duchess Dowager of Kingston[1], accused of having entered into a form of marriage with her second husband, the Duke, while her first husband still lived. Before the House of Lords, Mr. Hawkins, a surgeon called upon to testify as to his knowledge of any marriage between the Duke and Duchess, raised a preliminary objection to revealing information obtained by him in his professional capacity. He requested the determination of the House as to whether the question put to him should be answered[2].

Two factors are to be noted. Firstly, objection to the revelation of confidential medical information obtained in the course of the surgeon's professional calling was raised by the

surgeon himself, and as a question of evidentiary rules. More importantly, the revelation was in the context of a trial on a criminal charge of bigamy and was made before a court.

Lord Mansfield, speaking for the House of Lords, declared:

...a surgeon has no privilege to avoid giving evidence in a court of justice, but is bound by the law of the land to do it...a surgeon has no privilege, where it is a material question, in a civil or criminal cause, to know whether parties were married, or whether a child was born, to say that his introduction to the parties was in the course of his profession, and in that way he came to the knowledge of it[3].

He then went on to add:

If a surgeon was voluntarily to reveal these secrets, to be sure he would be guilty of a breach of honour, and of great indiscretion; but, to give that information in a court of justice, which by the law of the land he is bound to do, will never be imputed to him as any indiscretion whatever[4].

This decision, specific to the existence of any evidentiary privilege before a court of law, continues to influence the development of the law in Canada and elsewhere[5], despite the fact that the remarks concerning the disclosure of information outside of the context of a criminal or civil cause of action are clearly obiter.

As the influence of Lord Mansfield's decision has persisted, so have the issues that the case raises. It is unfortunate that the development of the law in this area has proceeded from consideration of the issue of confidentiality of personal information in the context of litigation. The recognized value of the protection of the confidentiality of the physician-patient relationship must be balanced against the equally important value of access to truth in the judicial process.

Of equal interest, and raising the question of the protection of personal information in the private law context, is an early Scottish case. In AB v. CD[6], the wife of an elder of the church gave birth to a child following only six months of marriage. The elder, at the request of the church,

called in two medical practitioners to determine whether the child was premature, as he believed it to be, or full term, requiring that the report be made in complete confidence and to himself only. The report of the attending physicians was unfavourable, finding the child to have been conceived before wedlock. However, disregarding the instructions of the client, one of the examining physicians left a copy of his report for the minister of the church.

The elder brought action against the physician in question, alleging breach of an essential condition of the contract, that of complete confidence, and claiming damages. Libel was also alleged, the physician reportedly having stated that the elder had been guilty of antenuptial fornication. The reported case deals with the question of whether the statement of claim revealed a triable issue, the physician citing the Duchess of Kingston case as authority for the proposition that no cause of action had arisen. The defendant argued that:

There might be an honourable understanding among the medical profession that secrecy formed a condition of the contract between the physician and his patient, but that understanding was not one which could be enforced at law. It is only where secrecy is the essence of the contract that an action of damages will lie; of this contract, for a medical man could not plead professional privilege as a ground of refusal to give evidence[7].

The case was allowed to proceed on the basis of breach of contract; Lord Fullerton specifically denying that the lack of a testimonial privilege barred the possibility of such a term in the contract between the parties. He held:

The question here is...whether the relation between such an advisor and the person who consults him, is or is not one which may imply an obligation to secrecy forming a proper ground of action if it be violated. It appears to me that it is, and that the present case...is one to which the principle may apply[8].

However, he added, the right of the client to secrecy might not be absolute in every case; other concerns might override the necessity for protection of the confidentiality of personal information.

The obligation may not be absolute. It may and must yield to the demands of justice, if disclosure is demanded in a competent court. It may be modified...(as for example) the disclosure being conducive to the ends of science - though even there concealment of individuals is usual[9].

It is suggested that this case too, raised elements of the problem of the protection of confidentiality of medical records that were to become recurring themes as the various forms of redress developed. It serves, as well, as an excellent example of the delicacy of information that medical personnel often receive, of the implications for personal embarrassment that its unwarranted release entails, and of the difficulty of quantifying, in any meaningful way, the damages suffered. Despite the fact that the court firmly based the action in breach of contract, elements of both an action for breach of confidence and an action in defamation are present in the framing of the action, as they continue to be until the present time. Finally there is a tone of moral indignation to the judgment that has continued to echo through Canadian and American case law dealing with the issue of confidentiality. It seems likely that this tone of indignation constitutes a valid measure of the degree of the failure of the common law to adequately meet the demands of the problem of the protection of the confidentiality of medical information.

...[T]hat a medical man, consulted in a matter of delicacy, of which the disclosure may be most injurious to the feelings, and possibly, the pecuniary interest of the party consulting, can gratuitously and unnecessarily make it the subject of public communication, without incurring any imputation beyond what is called a breach of honour, and without the liability to a claim of redress in a court of law, is a proposition to which, when thus broadly laid down, I think the court will hardly give their countenance[10].

Part I

The Physician's Testimonial Privilege

The emphasis on the protection of the confidentiality of communications between physician and client, once the client is before a court of law for whatever reason, has continued. The

debate as to whether such a privilege ought to be accorded and if so to whom, and with what exceptions, has dominated Canadian discussion of the protection of such information. It has fundamentally influenced American developments designed to provide for a private law remedy for disclosure, outside of the context of evidentiary rules.

Ironically, the debate concerning the necessity of granting a testimonial privilege most often seems to assume that, outside of the context of necessary in-court disclosure, any unauthorized disclosure would find a sanction in the private law, that it is only as an aid to the judicial search for truth that the value of non-disclosure is potentially outweighed by more important social values. Despite such an assumption, and despite it is submitted, the existence of common law remedies apt to protect unwarranted disclosure of confidential personal information, the presence or absence of a statutory privilege has often determined the success or failure of a private law remedy.

1. Recent Canadian Developments

The law with regard to an evidentiary privilege in Canada is in an interesting state of confusion, a confusion most likely due to the fact that belief in the necessity for, or undesirability of, such a privilege reflects a policy determination by the individual being questioned. Thus, there is some element of unpredictability in discussing the existence of such a privilege in the law of Canada.

The starting point for determining whether any such privilege exists is, of course, the Duchess of Kingston case[11]. Lord Mansfield stated categorically that no such privilege exists, at least with regard to criminal process, and that statement continues, for the most part[12], to be the law across Canada today. While this study is primarily concerned with private law remedies for unwarranted disclosure, a review of the protection of confidential information where the subject is before a court is justified on its own merit, and more particularly as reflecting Canadian uneasiness with the problems raised by such disclosures. Additionally, any recommendations as to further necessary protection would have to give consideration to whether such proposals ought to extend beyond the doors of the court room.

The debate as to the necessity for a physician-client privilege most often takes as its starting point consideration of the analogy between the relationship of attorney-client with that of physician and client. Often the most authoritative

statements denying the existence of a physician-client privilege are to be found in cases concerned with the extent or limits of the attorney-client privilege. These early statements, although clearly obiter, continue to influence the development of the law, despite the fact that they voice a certain perplexity as to why the privilege is extended in the one case and refused in the other[13]. Perhaps the most often cited of these is the statement of Jessel, M. R. in Wheeler v. Le Marchant[14], a case which was itself concerned with the extent of the attorney-client privilege.

...[T]he principle protecting confidential communications is of a very limited character. It does not protect all confidential communications which a man must necessarily make in order to obtain advice, even when needed for the protection of his life, or of his honour, or of his fortune. There are many communications which, though absolutely necessary because without them the ordinary business of life cannot be carried on, still are not privileged. The communications made to a medical man whose advice is sought by a patient with respect to the probable origin of the disease as to which he is consulted, and which must necessarily be made in order to enable the medical man to advise or prescribe for the patient, are not protected[15].

The question of testimonial privilege arises in the context of criminal and civil litigation. Tangential questions as to the admissibility of medical records have been raised[16], but we need not concern ourselves with these, as they go to the problems of best evidence and rules against hearsay, and are not concerned with methods of protecting the confidentiality of medical communications. Nor has Anglo-Canadian common law needed to concern itself in detail with the problem of the absolute or relative nature of the privilege that has faced those civilian jurisdictions where the privilege is recognized[17].

With regard to the domain of the criminal law, the law across Canada is uniform[18]. Theoretically, the value or injury inherent in disclosure of medical confidences in the context of criminal prosecution, must be weighed not only against the necessity for ascertaining the truth to the fullest extent possible, but also against the severity of the

consequences of a conviction for the accused, recognized in Canadian law primarily by the criminal law doctrine of burden of proof. The case of the Duchess of Kingston[19] is early authority for the proposition that the treating physician may not be excused from testifying even as to information obtained by him in the course of rendering professional services. This position is reflected in the Canada Evidence Act[20]. However, on occasion certain judges have indicated that they are not completely satisfied with this position[21].

Perhaps the most articulate proponent of the undesirability of admitting such evidence is Mr. Justice Haines of the Ontario High Court of Justice. In Regina v. Hawke[22], Haines, J., asked to consider whether to allow the testimony of a psychiatrist as to the credibility of a Crown witness, held that the trial judge has a discretion to exclude evidence of this kind.

What of the right of privacy of a witness, or the right to privilege from disclosure of communication in circumstances an ordinary citizen would consider confidential?...The doctor to whom he speaks has taken an oath of secrecy based on concepts older than our common law. He is responsible in damages if he violates that relationship. Everyone recognizes that confidentiality is essential to diagnosis and therapy[23].

While the statement by Haines, J. indicates some judicial concern with the protection of the confidentiality of medical information, his decision was overruled on appeal as to the existence of such a discretion and as to the relevancy of the psychiatric testimony[24].

The law on this point is clear. Neither an accused nor a witness may object on the grounds of privilege per se to the introduction of his confidential medical background. Nor does there appear to be, in Canada, clear judicial discretion to exclude otherwise admissible evidence even where the negative impact on the subject outweighs the positive judicial assistance the evidence might provide[25].

In the area of civil litigation there has been greater judicial reluctance to steadfastly apply the no privilege rule. The conflicting values to be reconciled continue to be the protection of the subject's privacy in the face of the judicial search for truth. Among the most influential of statements favouring the protection of the confidentiality of the medical

relationship to that of the possible assistance of such evidence in the judicial process is that of Mr. Justice Stewart in Dembie v. Dembie[26]. At issue was whether a psychiatrist treating one of the spouses was to be called upon to testify as to statements made to him by his patient during the course of treatment, and alleged to be relevant to the matrimonial dispute.

Mr. Justice Stewart, after pointing out to the witness and to counsel that no privilege existed[27], responded to the psychiatrist's stated preference for keeping such matters confidential by replying that while the legal position on the absence of such privilege is "quite shocking" it is "perfectly clear"[28]. Stewart, J. placed more emphasis on the need to protect the confidentiality of psychiatric communications than on those between a physician or surgeon and his client[29]. Informing the witness that he had no intention of finding him in contempt of court should he fail to respond to the question, Mr. Justice Stewart concluded in the following terms:

I recognize...that...it is my duty, as indeed I have sworn to do, to uphold the law without any conscience of a personal nature. It is, however, the genius of the common law to move with the times to recognize existing realities. When the laws involving privilege were first developed and promulgated there was no such thing as a psychiatrist, and, indeed, the surgeon was basically a barber and the physician little more than a herbalist...[30]

...[I] is not a matter of personal consideration that I have come to the conclusion that I have arrived at, but it is one, in my view, of the greatest interest in terms of public policy...[31]

This expression of support for some form of a medical privilege by Mr. Justice Stewart was responsible for the introduction of a private members bill before Parliament in 1964[32]. Designed to amend the Canada Evidence Act, the Bill proposed the inclusion of a statutory privilege to be extended to communications between clergy and penitents, physicians and patients, and social workers and clients; and was in accordance with the report of the Committee on Privileged Communications to the Ontario Civil Justice Subsection of the Canadian Bar Association.

The Bill was unsuccessful and, although further studies have resulted in recommendations both in favour of and against the introduction of such a privilege in one form or another, at this time no such addition has been made either to the Canada Evidence Act or to any of the provincial acts.

The position taken by Mr. Justice Stewart has been followed several times since. In G. v. G.[33], Landreville, J., referring to the judgment in Dembie v. Dembie, refused to order a marriage counsellor to answer questions concerning statements by the husband to the counsellor at a time of imminent marriage breakdown. The Master found that the statements to the counsellor could not be characterized as made in contemplation of litigation[34] and this was supported by Landreville, J.[35]. However, the Judge raised two additional objections to the introduction of such evidence. Firstly, he held the questions posed by the wife to the counsellor concerning the husband would elicit responses based, at least in part, on information supplied to the counsellor by the wife herself. To this extent the questions could be characterized as self-serving[36]. Then, citing Dembie v. Dembie, Mr. Justice Landreville added:

...it is inimical to bring into Court conversations, discussions and advice exchanged and received by husband and wife during that last period of cohabitation. With third parties they have unburdened their minds and heart in an honest effort to reconcile their differences. The failure in their efforts can bring no other conclusion but litigation of one sort or another between them. These confidential communications between the parties and their psychiatrists or counsellors are not aimed at creating a relationship but are designed to prevent the destruction of the matrimonial tie. I see from that distinction a special character placed on these communications between husband and wife and their counsellors. It is that of privacy, and they take place with the tacit but well existing understanding that they are to remain personal and private. Certainly if the law readily respects the secrecy of communications between opposing counsel to encourage settling differences, it is incongruous that their principals particularly in matrimonial cases, should not have the same privileges[37].

The Judge emphasized the development of psychiatry as a science since the decision in Wheeler v. Le Marchant and the nature of the common law as a living thing that "must constantly receive stimuli by reconsidering whether a given rule, hallowed by time, is still adequate under modern conditions[38]." He concluded:

Legislative action to bring unequivocal recognition of medical privilege would obviously be the rapid answer. But as statutory enactments normally come into existence after fait accompli and accepted (sic), laxity in admitting evidence pertaining to what the layman believes is privileged communication, is to be resisted[39].

The strong sentiments of Mr. Justice Landreville are all the more striking as at issue was the custody of the child of the marriage, a situation in which courts have traditionally emphasized that the determination of the best interest of the child is to take precedence, where necessary, over the interests of the spouses. However, Landreville, J. specifically noted that the question posed was not relevant to the child's welfare.

The welfare of the child was the determining issue in Robson v. Robson[40], one of the four recent cases which dealt with the issue of privilege for confidential communications. At issue in that case was the custody of the child of the marriage. The confidential communication in question had been made to a member of the John Howard Society following the release from prison of the defendant and, at least in part, in an effort at reconciling the parties to the marriage. Mr. Justice Wright ruled that the questions asked of the member of the John Howard Society, concerning that meeting, were to be answered, despite an objection, by counsel for the Society, on the grounds of privilege and public policy.

Mr. Justice Wright held:

...I consider that the public policy involved in this action, namely the welfare and the future of the infant child, predominates over any of the public policies...and is, in any event, the public policy which it is my duty to serve in considering the issue in this case[41].

Mr. Justice Wright was careful to point out that he need not distinguish the cases of Dembie v. Dembie and G. v. G., as in the case at bar the parties themselves had both testified at length as to the meeting in question, thereby acquiescing in its further discussion by the John Howard Society representative[42].

In England the question of common law privilege has had the same judicial history as in Canada. However, the English courts have recognized a common law privilege applicable where confidential disclosures are made by one or both parties in a matrimonial dispute to a third party in an attempt to foster reconciliation[43]. The privilege has been held to extend to any person in such a position, regardless of actual training, and would clearly apply to a medical practitioner whether consulted in his capacity as treating physician, or for his specialty in matrimonial problems, or simply in his role as a friend of one or both of the parties. In the Canadian case, Shakotko v. Shakotko[44], Grant, J. applied the English caselaw on this question to disclosures made by the parties to a physician specializing in marital difficulties. The privilege in such situations can be seen as an application of the attorney-client privilege applicable to inquiries made in anticipation of litigation. However, in most instances the English courts have paid little attention to that element, and the privilege has taken on a certain life of its own.

Mr. Justice Grant also held that a similar privilege was provided for by s.21(2) of the Divorce Act[45], going so far as to hold that the language of that section is imperative and that evidence may not be given by the so-called conciliator even where all parties concerned consent[46].

In the most recent Canadian case to consider whether any privilege exists or is appropriate, Wang, J. of the Provincial Court (Family Division) reviewed the developments in Canadian law of the last fifteen years. In Re S.A.S.[47], a case involving the right of Mrs. S.H. to have custody of the child, Wang, J. concluded that the court has a discretion as to whether or not a psychiatrist will be called upon to testify. That discretion is to be exercised whenever the welfare of a child is involved, and disclosure to be ordered wherever the welfare of the child so requires[48]. It must however be pointed out that these remarks are technically obiter, as similar psychiatric reports had been filed in past proceedings with the apparent consent of the subject, in a manner tantamount to waiver of any privilege.

What conclusions can be drawn from this recent series of haphazard, but interesting, cases? At this time the position with regard to criminal law matters seems fairly stable, neither the accused nor a witness appear free to object to the introduction of otherwise confidential personal information on any grounds of privilege per se, although the rules of evidence provide other safeguards which may be applicable in a particular set of circumstances. On the civil side the legal position seems somewhat less clear. It is interesting to note that all of the discovered cases concerned with the disclosure of communications given in confidence have arisen in the Province of Ontario. This forward looking group of judgments raise a series of questions concerning the existence and necessity of the privilege that remain to be answered in a systematic way. Certain of these have been discussed in the United States, where the development of the law in this area has been slightly less haphazard.

Against the early and categorical statement that no medical privilege exists we may now consider whether or not in fact such a privilege has been recognized, at least in certain circumstances, by the courts of Ontario. If so, is it to be applied only in matrimonial disputes, and those only where no overriding concern as to the welfare of a child is involved? Is this privilege merely the application of a line of English caselaw in development since the judgment of Lord Denning in McTaggart v. McTaggart? If so, is this anything more than the traditional attorney-client privilege, or does it have an independent status of its own? What is required to waive any right to privilege and who may exercise the waiver? Finally, what are the implications of the holding of Grant, J. in Shakotko v. Shakotko that section 21(2) of the Divorce Act not only makes certain communications privileged but goes further to prohibit their disclosure, which prohibition would apply in any proceeding under federal legislation?

The series of Ontario cases indicating that a medical privilege may exist in certain circumstances is anomalous. However in 1975, in the case of Slavutych v. Baker[49], the Supreme Court of Canada indicated that the categories of privileged communications may, in fact, be more flexible than had previously been thought. Slavutych v. Baker concerned dismissal proceedings taken against Professor Slavutych by the University of Alberta. These proceedings were based almost entirely upon the alleged unprofessional conduct of Professor Slavutych in somewhat candidly filling out a tenure evaluation form concerning one of his colleagues. The form was prominently marked "Confidential" and was solicited upon the promise that it would be kept confidential. Professor Slavutych received an

undertaking that the form would be destroyed once a tenure determination upon the colleague in question had been taken. In breach of these undertakings the form was not only maintained in the files of the University, but was to form the grounds upon which the dismissal attempt against Professor Slavutych was based.

In the Supreme Court Mr. Justice Spence, adopting the reasoning although not the result of the Alberta Court of Appeal[50], referred to a series of criteria developed by Wigmore to determine whether the tenure evaluation form was privileged communication and therefore inadmissible in evidence. The Wigmore criteria, adopted by the Court to establish privilege against disclosure, are that:

(1) The communications must originate in a confidence that they will not be disclosed.

(2) This element of confidentiality must be essential to the full and satisfactory maintenance of the relation between the parties.

(3) The relation must be one which in the opinion of the community ought to be sedulously fostered.

(4) The injury that would inure to the relation by the disclosure of the communications must be greater than the benefit thereby gained for the correct disposal of litigation[51].

These same criteria were referred to by Mr. Justice Haines in Regina v. Hawkes and by Mr. Justice Wang in Re S.A.S.

Mr. Justice Spence, in reviewing the circumstances of the case, concluded that the four criteria had been met and the tenure evaluation form ought to be considered inadmissible[52]. Two points must however be noted. The conclusions of Mr. Justice Spence concerning the use of the Wigmore criteria and their applicability in the circumstances of the case are obiter, the true basis of the decision being an action for breach of confidence[53]. Secondly, although the remarks by Mr. Justice Spence clearly raise the possibility of a broadening of the area of confidential communications to be achieved by a case by case application of those criteria, Wigmore himself felt strongly that the nature of communications between physician and client failed to meet the test he had set out. How persuasive the

opinion of the distinguished author of the criteria might be is open to question. Nonetheless, it is not difficult to imagine a court determining that the criteria, when applied to circumstances surrounding a particular medical communication, result in a determination that evidence as to that communication is inadmissible.

Despite these spontaneous judicial developments in the Province of Ontario, opinion continues to be divided as to the appropriateness of providing a protected status to communications between physician and client, and possibly other professionals and their clients as well. In the two most recent studies of the law of evidence, that of the Ontario Law Reform Commission[54] released in 1976 and that of the Law Reform Commission of Canada[55], released in December of the preceeding year, the two Commissions reached opposite conclusions as to the necessity and appropriateness of introducing such a privilege. The Law Reform Commission of Canada recommended a general professional privilege against the disclosure of "any confidential communication reasonably made in the course of the relationship[56]." However, in every case the privilege would be available only if the public interest in the privacy of the relationship was determined to outweigh the public interest in the administration of justice.

Case law would undoubtedly develop indicating which relationships could be said to be more in need of protection than is the public interest in the administration of justice. However, it is not entirely clear to what extent a general test is to be applied in every case, or to what extent the particular circumstances are to be considered. To the extent that particular circumstances are relevant to the balancing process, an element of unpredictability as to whether or not a privilege will be found appropriate will exist. Such uncertainty cannot foster that sense of complete privacy and confidentiality which forms the basis of the position in favour of establishing some form of privilege in this area. Such an approach does provide for an admirable flexibility, focussing attention on the nature of the relationship to be protected rather than on an arbitrary categorization of professions[57]. However, such an approach seems only slightly more likely to limit the number of exceptions to a general rule of privilege[58].

A contrary conclusion was reached by the Ontario Law Reform Commission. In considering the appropriateness of a privilege for communications between accountants and clients, reporters and their sources, physicians and patients, and clergy and members of their congregations, the Commissioners concluded:

None of these relationships are fundamentally or historically the same as that which exists between the solicitor and his client. The argument put forward is that they are all based on confidence; however, as we have pointed out, the solicitor and client relationship is based not on confidence, but arises necessarily out of the basic right of the client to equality before the law. The extension of a statutory privilege to any of the relationships we have mentioned would result in closing to the judicial process wide areas in its search for truth. We have come to the conclusion that this consideration outweighs the arguments put forward in favour of providing statutory protection for the relevant communicants[59].

It is worth noting that the argument in favour of a privilege under such circumstances is not based by any means, solely on the similarity between the relationship of solicitor and client and other professional groups and their clients, but on a very specific set of values, some of which have been expressed by Ontario courts in the cases reviewed above. Furthermore, the recommendation of the Federal Law Reform Commission would not close certain areas to investigation per se, but rather engage the court in a determination of values in any given set of circumstances[60].

Two neighboring jurisdictions, that of the United States and the Province of Quebec, provide the protection of a testimonial privilege to most communications between physician and client. A brief look at each will draw attention to the elements to be considered in recommending any such privilege.

2. The American Experience

In 1828 the State of New York passed legislation providing for statutory recognition of a physician-client privilege[61]. In the intervening years almost all of the remaining states have followed suit[62]. With only minor variations, the texts providing for such privileges are similar to scope and application. A review of their common characteristics is indicated, as useful to the determination of whether or not such a privilege ought to be provided in the Province of Ontario and, if so, under what conditions. Additionally, the existence of a physician-client privilege has had a profound effect on the development of

private law remedies for disclosure of confidential information in all of the states, regardless of whether they recognize the privilege or not[63].

The general characteristics of the privilege are two. Firstly, disclosure of communications arising in the course of treatment is prohibited. This may extend to communications in the course of treatment or diagnosis, or may be formulated to cover all communications necessary to enable treatment of the client. Generally, such a clause is interpreted so as to require the existence of a "professional relationship," and has been held to exclude court ordered and similar examinations.

Secondly, the statutes generally require that the communication be seen as confidential by the communicant at the time of its disclosure to the physician or other professional covered by the statute.

A series of exceptions to the right to claim the privilege have been devised by the courts and, less frequently, in the text of the statutes themselves. Primary among these is the so-called patient-litigant exception[64]. An individual who places in issue his own physical state by way of personal injury litigation, cannot claim privilege. The same often holds true of the individual who places in issue his mental competence[65].

A general exception to the right to claim privilege is often, but not always, specified with regard to criminal proceedings, or in some cases, with regard to particular offences such as assault and murder, or with regard to defences raising questions of sanity[66]. In addition, certain situations have, on occasion, been held to give rise to an overriding need for disclosure[67]. In particular, custody disputes are often held to require the disclosure of otherwise privileged communications on the grounds of supervening state interest in the welfare of children[68].

The privilege is primarily to be claimed by the patient or client himself[69]. It may only be claimed in his interest, and may not be insisted upon where he has given a legally valid consent to disclosure. Certain of the legislative texts require that the physician or other professional claim privilege on the patient's behalf; although should consent to disclosure be unequivocally expressed, the practitioner must comply with the patient's preference for disclosure[70]. Should the patient be incompetent or deceased, the privilege may be claimed by his legal representative, so long as there are no grounds for an allegation that the representative stands in a position of adverse interest[71].

Claims of privilege under statutes providing for a physician-client privilege may be waived in much the same manner as may other privileges. In general, waiver must be voluntary, by one legally competent or his appropriate representative and may be provided for by contract[72].

Interpretation of these texts has given rise to several recurring difficulties. Firstly, the applicability of the statute often turns on whether the relationship between the professional and client can be characterized as the treatment relationship most often required by the statutory language, as opposed to a mere examination for specific purposes, usually held to be outside the purview of the statutory language.

Secondly, where the statute requires that the communication be made in confidence, difficulties may arise in determining whether this element was present. Questions also arise as to the basis of any response a professional may offer to in-court examination. Almost any communication made to a treating physician will be privileged[73], whether verbal or resulting from a non-verbal communication understood by the treating physician because of his training. However, courts have often held that observations made by the professional which he would be competent to make in his capacity as layperson are not subject to privilege[74], and that furthermore a physician may be called upon to answer hypothetical questions put to him as an expert witness[75]. The problem in drawing the line between what is and what is not privileged, in such a context, is obviously a difficult one.

Finally, where statutes refer to a specific profession, the scope of the definition will often be called into question. This is particularly so as what is to be protected is more clearly a certain quality of confidence and trust in a relationship, whereas the statutes themselves are most often drawn in terms of a particular profession or professions.

3. The Experience in the Province of Quebec[76]

French law has recognized a form of medical privilege since before the Revolution[77]. The Province of Quebec, while basing its private law on the French civilian tradition, did not recognize any form of medical privilege until 1909[78], at which time the basis of a medical privilege was included in legislation providing for the professional corporation of physicians and surgeons. This state of affairs continued until 1965, when an amendment was made to article 322 of the Quebec Code of Civil Procedure[79] so as to expand the article providing for

solicitor-client privilege to refer specifically to the physician-client privilege. Prior to the 1965 revision of the Code of Civil Procedure the provision in the Medical Act that a physician could not be compelled to reveal confidences obtained in his professional capacity was considered sufficient to establish a medical privilege of general application, giving rise to a right of silence before the courts of the Province. The rationale for such an extension of the section of Medical Act was that the legislation was of public order and of general application[80]. While such easy acceptance of a testimonial privilege arising out of a statute providing for a professional corporation may seem less than obvious to one trained in the common law tradition, that such was the case was never seriously questioned in Quebec. Undoubtedly, this was due in part to the long French tradition of recognition of such a privilege. The privilege is now provided for by article 308 C.C.P.

Critical discussion of the privilege in the Province of Quebec has centered around its effect on the conflicting values of the judicial search for truth and the necessity for the protection of the confidential nature of the medical relationship. At a practical level this debate was reflected in an early rejection of the French position that the privilege was to be exercised by the physician only, who could therefore refuse to divulge information obtained in his professional capacity regardless of an express direction from his client so to do[81]. Additionally, it was argued that medical privilege was too often invoked as an auxiliary of fraud and that an appropriate solution would be to leave the final determination as to whether to testify in neither the hands of the client or physician but within the discretion of the court[82]. The issue of the physician's right to refuse to testify, regardless of a direction from his client so to do, was resolved by the text adding the privilege to the Code of Civil Procedure. If the client so requests, the physician is bound to testify.

Unwarranted disclosure of information obtained in confidence will give rise to an action for breach of an express or implied term of the professional contract[83], should the parties have been in a contractual relationship, or to an action in delict under article 1053 C.C., if they were not[84].

Part II

Actions for Unwarranted Disclosure of Confidential Information

In common law Canada, neither physician nor client may claim the privilege of refusing to testify, or to allow

testimony, as to information obtained as a result of the relationship. The value of such information to the process of the judicial search for truth takes precedence, in our legal system, to the value inherent in protecting the confidentiality of the particular relationship in question. It is clear, however, that outside of the context of admissibility of evidence and compellability of a witness, no value lies in allowing indiscriminate disclosure by the physician or similar professional, of information obtained in his professional capacity. Where such a disclosure is made, a variety of actions may be taken by the injured client. Among the most appropriate are actions alleging defamation, breach of contract, breach of confidence, actions based on breach of statute and an action for negligence. These will be considered in turn, to determine their efficacy as sanctions for unwarranted release of confidential health information by health professionals.

A. Actions in Defamation

An action in defamation, assuming the requirements of the tort of defamation are present, may well be the easiest and most appropriate basis for recovery from the damage caused by unwarranted comment on confidential matters concerning plaintiff's medical history. As we noted earlier, plaintiffs often frame an action alleging unwarranted disclosure in defamation and on some other ground, such as breach of contract, at the same time. While an action framed in defamation has the advantage of being easily recognized and appreciated by a common law court, its requirements make it less than satisfactory as a device to protect persons from unwarranted disclosure of confidential medical information. This fundamental lack of effectiveness is often reflected in the tone of decisions of courts before which such actions are brought. Certain elements of the action in defamation, specifically those going to the defence of qualified privilege are, however, highly suggestive of elements to be considered in proposing more appropriate protections for information disclosed in confidence.

The classic Canadian application of the rules of defamation to a situation arising out of disclosure of confidential medical information arose in the case of Halls v. Mitchell[85] decided by the Supreme Court in 1928. Halls, a civil engineer employed by C.N.R., filed a claim with the Workmen's Compensation Board for damages to an eye which he alleged resulted from the blow of a door at his place of employment. In the process of investigating the claim, Halls was examined by the defendant physician, the medical officer for the C.N.R. As Halls had been treated by the defendant on a private basis some years earlier, the defendant consulted his own records of that earlier visit.

Those records indicated Halls had suffered from venereal disease while in the Army. The defendant communicated this information orally to Hall's treating physician, by letter to the claims officer of the C.N.R. and to a physician called in for independent examination. He also made formal inquiries as to the plaintiff's medical history while a member of the Canadian Armed Forces. On examination of the plaintiff's medical record while in the Armed Forces, it became clear that plaintiff had not suffered from venereal disease but rather from a disease of the heart valve, the abbreviation for which closely resembled that for venereal disease. However, the plaintiff's claim for compensation was refused, defendant refused to withdraw his statement as to a history of venereal disease in the plaintiff and when plaintiff instituted an action in defamation he was summarily fired by C.N.R.

That the allegation of disease was not true was established. The defendant pleaded qualified privilege.

Untrue imputation of current infectious disease of a certain type was early recognized by the common law as so disruptive of the subject's social relations as to be actionable per se. No inquiry was necessary as to whether the statement that a person suffered from such a disease would tend to lower him in the estimation of his fellow men[86]. Imputation of other, less stigmatizing, disease would be subject to such an inquiry. Thus, the imputation of venereal disease in Halls v. Mitchell was actionable per se, in the absence of an appropriate defence. There being no truth to the imputation, defendant pleaded qualified privilege. If established, qualified privilege would exonerate the defendant, in the absence of malice.

A defence of qualified privilege will turn on the facts of the particular case. In effect defendant says "I have mistakenly attributed certain qualities to the plaintiff, although I have done so without malice. Whether these qualities can be characterized as defamatory because actionable per se or because they tend to lower plaintiff in the estimation of his fellow man, I did so in the honest belief, which all reasonable men would share, that I was revealing these attributes under the compulsion of a higher duty."

If such a defence is recognized by the law where the actual allegations prove to be false, obviously it ought not to be summarily dismissed in considering protection to be provided for the release of information that is, in fact, true.

In many instances courts have recognized that, on the facts of a particular case, the defence of qualified privilege ought

to be allowed where an action in defamation has been brought against a physician. However, in Halls v. Mitchell Mr. Justice Duff, speaking for the majority, found the defence to be inappropriate to the particular circumstances. Both his reasons for refusing to allow the plea of privilege, and his obiter remarks concerning a physician's responsibilities with regard to information obtained by him in the course of his profession, are of interest.

The defence of qualified privilege ought to be allowed only where the defamatory statement is:

...fairly warranted by some reasonable occasion or exigency, and when it is fairly made in discharge of some public or private duty, or in the conduct of the defendant's own affairs in matters in which his interests are concerned. The privilege rests not upon the interests of the persons entitled to invoke it, but upon the general interests of society, and protects only communications "fairly made"...in the legitimate defence of a person's own interests, or plainly made under a sense of duty, such as would be recognized by "people of ordinary intelligence and moral principles[87]."

It is not sufficient...that the defendant may, quite honestly and not without some ground, have believed that the interest or the duty existed. There must, in fact, be such an interest or such a duty as, when all the circumstances are considered, warranted the communication[88].

Mr. Justice Duff held that the duty upon the defendant was to take measures to see that the Workmen's Compensation Board was properly informed, but that this obligation did not entail any duty to betray the professional confidences of a personal patient[89]. The Court went even further, citing Macintosh v. Dun[89a] as authority for the proposition that:

...the fact that defamatory matter has originated in breach of confidence, to the knowledge of the defamer, or indeed, the fact that it was produced under a system which contemplated the violation of confidence as a source of information, may

constitute a conclusive reason for rejecting the claim of privilege[90].

Furthermore, a party who takes advantage of such breaches of confidence knowing the nature of their origin, in the opinion of Mr. Justice Duff, would share the responsibility of the unworthy confidant.

...[T]he railway company, in requiring, or knowingly taking advantage of breaches of confidence on his part, would share his responsibility. In respect of communications in breach of confidence, the courts afford protection as against the person in whom confidence was originally reposed; and the law is not so futile as to withhold such protection as against third persons, who, in acquiring knowledge of confidential matters, have also become acquainted with their character and origin[91].

The tone of Mr. Justice Duff's decision suggests that absent grounds for an action in defamation, as for example if plaintiff had in fact been infected with a venereal disease, defendant would not have been released, for that reason only, from liability for disclosure of information given to him in confidence. Mr. Justice Duff makes specific mention of the obligations of a physician in protecting the confidence of his client.

Firstly, Mr. Justice Duff suggests that the defendant, having no personal recollection of plaintiff's having informed him of the existence of venereal disease, and having been informed by plaintiff's current physician that plaintiff claimed never to have so suffered, was at fault in relying on his own records compiled several years earlier[92]. There is also an indication that the defendant ought not to have continued with the investigation at all, once he had determined that he stood in the position of previously treating physician to plaintiff[93]. Such an action might, he suggests, be formed in deceit[94].

We are not required, for the purposes of this appeal, to attempt to state with any sort of precision the limits of the obligation of secrecy which rests upon the medical practitioner in relation to professional secrets acquired by him in the

course of his practice. Nobody would dispute that a secret so acquired is the secret of the patient, and, normally, is under his control, and not under that of the doctor. Prima facie, the patient has the right to require that the secret shall not be divulged; and that right is absolute, unless there is some paramount reason which overrides it. Such reasons may arise, no doubt, from the existence of facts which bring into play overpowering considerations connected with public justice; and there may be cases in which reasons connected with the safety of individuals or of the public, physical or moral, would be sufficiently cogent to supersede or qualify the obligations prima facie imposed by the confidential relation[95].

Although in the particular circumstances of Halls v. Mitchell the Supreme Court of Canada found the statement defamatory, and that no valid defence had been raised, a defence of qualified privilege may well be available to cover certain disclosures by a physician concerning the state of health of another. Each case must turn on its facts. Thus, in C. v. D.[96], D was informed by his patient F that the source of the venereal disease from which F suffered was C, employed by E. D, being E's physician, warned E of the possibility of infectious disease in C. D also so informed C's father. In an action brought by C for defamation, D pleaded qualified privilege. The court found a clear moral duty to so inform E and held D protected by the defence of qualified privilege where the communication was to one of D's current patients[97]. It held that the failure of D to investigate further, before making disclosure to E, was not evidence of malice[98].

In the United States, several early cases dealing with unauthorized disclosure were framed in defamation; several of these resulted in the successful plea of qualified privilege[99]. The leading case sounding in defamation is that of Berry v. Moench[100]. In that case, Dr. Moench wrote a letter giving his impressions of Mr. Berry, whom he had treated some seven years earlier. This letter was written to a Dr. Hellewell who requested the information on behalf of previous patients of his, whose daughter was "infatuated" with Mr. Berry. That letter contained alleged defamatory information concerning the character of Mr. Berry. Dr. Moench pleaded the defence of qualified privilege. The decision evidences, as do so many of the decisions in these cases, a blurring of the lines between

defamation and breach of confidence. Crockett, J., of the Utah Supreme Court, in considering the allegation put forward by Dr. Moench that the statements contained in the letter were true, said:

It is recognized that ordinarily the truth is a defence to an action for libel or slander. However, in the instant case there is the special circumstance to reckon with, that a doctor-patient relationship existed between the parties in connection with which Dr. Moench acquired the information upon which he based the letter[101].

With all due respect, this confuses two different causes of action. That the action in defamation is usually inappropriate to the situation with which we are concerned is clear, exactly because truth is a defence to the action, whereas the disclosure of the truth in such circumstances can be as unpleasant and cause as great a damage to the subject as can publication of falsehood. Mr. Justice Crockett continued by outlining the situation in which the defence of qualified privilege is available as being:

Where life, safety, well-being, or other important interest is in jeopardy, one having information which could protect against the hazard, may have a conditional privilege to reveal information for such purpose, even though it be defamatory and may prove to be false[102].

Even where the circumstances give rise to the possibility that the communication is privileged, further precautions must be taken. Indifference to the truth of the facts communicated destroys any claim of privilege, as does negligence in attempting to ascertain the truth[103]. There is a duty to use reasonable diligence to be fair in the information communicated, by indicating where sources may be less than reliable[104]. Information communicated ought to be limited to the relevant[105]. Publication should be as direct as possible and to as limited a group as possible[106].

While upholding the conclusion of the trial judge that the communication came within the domain of qualified privilege[107], Mr. Justice Crockett remanded the case for a new trial to consider whether one of the excesses detailed above destroyed the defence in the circumstances. We like to think

that Mr. Justice Duff, faced with the same facts, would have found defendant not protected by privilege.

There has been a general tendency to import the elements of, and tests for, a situation of qualified privilege from the law of defamation into other forms of action, whether based in breach of confidence or even privacy[107a]. The existence of such a defence provides an element of flexibility and a recognition that there are limits to the protection which the law is willing to extend to confidential communications at the risk of injury to a third party. The only difficulty posed by this kind of legal borrowing is a certain confusion of the forms of action without an examination of the common elements of those actions. In Berry v. Moench the court stated:

If the doctor could with impunity publish anything that is true, the patient would be without protection from disclosure of intimacies which might be both embarrassing and harmful to him. This would make him reluctant to tell some things even though they might be important in the treatment of his ills. For this reason it is obligatory upon the doctor not to reveal information obtained in confidence in connection with the diagnosis or treatment of his patient. It is our opinion that if the doctor violates that confidence and publishes derogatory matter concerning his patient, an action would lie for any injury suffered. That of course, presupposes the absence of any privilege...[108]

In Simonsen v. Swenson[109], an action for disclosure of information obtained as a result of physician-client relationship and based on breach of confidential relationship, the Nebraska Supreme Court held that in making disclosures in accordance with a higher duty than that owed his client "...a physician must also be governed by the rules as to qualifiedly privileged communications in slander and libel cases[110]."

It is the logical corollary of the principles of qualified privilege that courts have, in certain cases, gone so far as to impose a duty to disclose[111]. The most recent and most controversial of these is the decision of the California Supreme Court, Tarasoff v. Regents of University of California[112], in which the Court held a psychiatrist and psychologist responsible for failing to notify Miss Tarasoff or her family of the threat against her life of a Mr. Poddar. Poddar had consulted the

counselling services of the University and had expressed such an intention to the counsellor there. Thus, it appears that where the courts consider the problem of protecting confidential communications they do so on a continuum starting from absolute protection, where any release would be actionable, to the possibility that the confidant will believe he is under a necessity to disclose with which the courts may or may not agree, to an obligation to disclose, wherein the failure to disclose may itself be actionable. The determination of at which point on the continuum one lies depends on the circumstances of each case.

B. Breach of Contract

In considering the protection of confidential medical information, Canadian courts and jurists have concerned themselves almost entirely with problems of the use of such information as evidence in judicial procedures, while expressing confidence that unwarranted disclosure outside of the context of judicial process would be actionable. In the United States, where somewhat greater attention has been paid to this problem few actions have been based on breach of contract, despite the fact that the relationship between treating physician and client has long been characterized as contractual in nature. The failure to characterize the unwarranted disclosure as a breach of contract may be due in part, to a dissatisfaction with the scope of contractual damages as a mechanism of compensation in such a situation[113]. Nonetheless, it is submitted that such an action is available to compensate for unwarranted disclosure; and would not be subject to the limitation inherent in the action for defamation, that the information disclosed was true[113a].

In most cases the terms of a contract between treating physician and client would not be reduced to writing and would have to be supplied by the courts. In the absence of any specific reference to the obligations of the physician with regard to information obtained from his client, it is submitted that a court could easily find that a requirement of confidentiality ought to be an implied term of any such contract[114]. In general, where a custom or usage is notorious, that custom will form the basis of an implied term on the theory that the parties certainly intended it so to be. It is submitted that the notion of confidentiality contained in the Hippocratic Oath and in various other Codes of Medical Ethics[115] forms the basis of a notorious, certain and reasonable custom clearly not contrary to law, and therefore appropriate to the importation into any medical contract. This would also be the case where statutory or professional

requirements for the protection of medical records are imposed on treating institutions[116]. Such requirements would then become an implied term of a medical contract between an institution and its client. Breach of contract would, in either case, give rise to an action in damages.

In Hammonds v. Aetna Casualty and Surety Company[117] plaintiff brought action against the insurer of his treating physician for inducing disclosure of plaintiff's confidential medical history, and influencing the treating physician to withdraw his services from plaintiff. In considering a motion to dismiss, the United States District Court made the following observations:

Any time a doctor undertakes the treatment of a patient, and the consensual relationship of physician and patient is established, two jural obligations (of significance here) are simultaneously assumed by the doctor. Doctor and patient enter into a simple contract, the patient hoping that he will be cured and the doctor optimistically assuming that he will be compensated. As an implied condition of that contract, this Court is of the opinion that the doctor warrants that any confidential information gained through the relationship will not be released without the patient's permission. Almost every member of the public is aware of the promise of discretion contained in the Hippocratic Oath, and every patient has a right to rely upon this warranty of silence. The promise of secrecy is as much an express warranty as the advertisement of a commercial entrepreneur. Consequently, when a doctor breaches his duty of secrecy, he is in violation of part of his obligations under the contract[118].

It is submitted that this is equally the case in both common law and civil law Canada, and that an action for breach of contract would lie whenever there is an unwarranted disclosure of information obtained in confidence; regardless of the accuracy of the information.

C. Action for Breach of Confidence

A certain amount of attention has recently been focused on the action for breach of confidence as an appropriate protective

mechanism in situations such as the one with which we are concerned, by the Younger Commission Report on Privacy[119] in Great Britain. The Commission concluded that the action "more directly or more comprehensively" protects privacy than does any other of the common law remedies[120]. The Commission did point out, however, that the action has yet to be fully developed by the courts[121]. The action in breach of confidence has been considered recently by the Supreme Court of Canada in Slavutych v. Baker[122].

The action in breach of confidence is originally an equitable remedy and its equitable origins give rise to certain of its limits as effective protection in situations such as ours. The most famous early instance of its application is in the well-known case of Prince Albert v. Strange[123], wherein an injunction was granted to prohibit the publication of a catalogue describing etchings made by the Prince and Queen Victoria. The catalogue was based on the information obtained by one J. T. Judge from Middleton. Middleton was employed by Brown who had had a contract to print some of the etchings for the private enjoyment of the Royal Family. In breach of confidence, Middleton, who was not a party to the cause, sold copies of the etchings to Judge. Judge was enjoined from using information which he must be taken to have known was sold to him in breach of confidence or breach of trust.

Recently there has been a great deal of development of this cause of action in the field of commercial information[124], although it is generally recognized that there are three categories of confidential information: literary ideas, details of an individual's private life, and industrial or commercial information[125]. The action is particularly appropriate where the parties ad litem are in no contractual relationship, and particularly where the plaintiff wishes to proceed against a third party recipient of information which the plaintiff considers confidential to himself. The existence of a right of action for breach of confidence requires neither the establishment of a contractual relationship nor of a classic proprietary interest in the information communicated[126].

Certain elements of the action have yet to be fully developed, and these uncertainties as to the requirements and implications of the action are as applicable to the unwarranted release of personal information as to the unwarranted use of industrial secrets.

It is not entirely clear whether an action for breach of confidence will lie only if the recipient is aware that the source is questionable at the time of receipt of the

information, nor whether an action will lie where the information was innocently received but where the third party later realizes the impurity of the source. Questions have been raised, as well, where the recipient has either paid for the information in good faith or even innocently expended funds in making use of the information[127]. While these difficulties are more characteristic of actions for breach of confidence involving industrial secrets, where amounts spent and expended are potentially quite large, a spill-over of principles developed in that context could be highly inappropriate to the situation of the release of medical information, and limit the utility of the action in situations involving the disclosure of personal information. Thus to order compensation to the party whose confidence was breached may be appropriate where the information involved was a trade secret, to compensate the plaintiff alleging disclosure of medical records by ordering payment of their value to him would be patently inadequate[128], and tantamount to a forced sale. Furthermore, the question of compensation assumes that damages are available, although the source of the action is in the courts of equity. To this date the few cases dealing with personal information, as opposed to trade secrets, have resulted in the granting of an injunction only, but an injunction is obviously only appropriate prior to disclosure.

Equity also provides for the remedy of delivering up for destruction, available even against a bona fide purchaser, and utilized in Prince Albert v. Strange. While more appropriate to disclosure of personal information than is compensation, the remedy is still inadequate to our situation. In equity it is usually combined with an injunction.

Nor is it clear from the cases concerned with disclosure of trade information whether a confidential relationship is recognized by the motives of both parties (i.e. doctor and client) by the motives of one party only, or by the standard of the reasonable man[129]. However, it is submitted that courts would have no difficulty in so characterizing the physician-client relationship, regardless of the definition used. It does not appear that the fact that the parties were contractually bound, as we have alleged a physician and client most often are, is a bar to basing an action in breach of contract and in the alternative in breach of confidence[130].

Despite the enthusiasm of the Younger Commission for the action for breach of confidence, the only recent British decision dealing with the issue in the context of personal information is that in Argyll v. Argyll[131]. In that case Duke was restrained from publishing marriage confidences in an

article in the Sunday press on the grounds that such a publication would be a breach of marital confidence.

The court based the injunction on several grounds relevant to our situation. Firstly, an obligation of confidence the breach of which would give rise to a cause of action need not be express, but could be implied. Nor need it find its source in a contract, nor a proprietary interest[132]. However, should the equitable remedy require a contractual or proprietary basis, a sufficient basis could be found in the marriage contract[133]. Divorce did not terminate the obligation to keep confident communications made during marriage[134]. Secondly, relief would be granted not only against the person acting in breach of confidence, but against third parties who had received the confidential information[135]. Finally, there is a suggestion that public disclosure of similar information by the plaintiff would release the defendant from his obligation of confidence[136]. It is worth noting that the Court protected the confidence of the matrimonial relationship, cognizant that the rules of evidence were otherwise[137].

Clearly the decision in Argyll v. Argyll would serve as authority for alleging that a plaintiff had an equitable right of injunction to prohibit disclosure of medical confidences, even in the absence of a contractual relationship. However, the questionable right to recover damages and the manner of damages makes breach of confidence, as a remedy, only potentially preferable to an action for breach of contract.

While of great interest, in that an action for breach of confidence seems to generate rights against third party recipients whether or not they are complicit in obtaining the information in breach of confidence, the uncertainties in this area as to available damages lessens the value of the action substantially. Nonetheless the development of this right of action will be of a certain interest both in the particular situation of breach of confidence and in developing protection for privacy in general.

There is some suggestion in the judgment of Ungood-Thomas, J. that determination of whether or not a communication disclosed is rightly described as within the protected zone where confidentiality applies is not sufficient. Instead the right to protection is to be determined with regard to each statement, rather than on the basis that the communication arises within a named relationship described as confidential[138]. This seems an unwieldy process, and unnecessary, except possibly in determining the validity of a claim to testimonial privilege. While determining objections to testimony should be, as

Ungoed-Thomas, J. points out[139], a simplified process, it is only in the context of the judicial search for truth that there is, at least in the writer's opinion, any reason to treat communications arising out of a relationship described as having the characteristics of confidentiality, as other than presumed confidential in their entirety, de juris and de jure.

That Argyll v. Argyll, and the application of the equitable doctrine of breach of confidence in situations other than commercial is good law in Canada, is clear. In Slavutych v. Baker[140] the Supreme Court of Canada applied the doctrine so as to deny the University of Alberta the right to utilize a tenure form report, given in confidence and clearly so marked, in proceedings for dismissal against the individual responsible for that report[141].

Certain American caselaw speaks of a breach of confidence as giving rise to a right of action where there has been disclosure of confidential medical information[142]. However, it is often not clear whether the breach of confidence spoken of has as its legal basis a breach of a term of contract (express or implied), breach of a duty of confidence giving rise to an action in tort, an equitable duty analogous to breach of trust, or simply a breach of confidence from which a court may conclude that "...for so palpable a wrong, the law provides a remedy[143]."

Finally, the interaction of principles of qualified privilege with the action for breach of confidence has yet to be explored[144]. Do those same principles provide a defence or possibly serve as the basis for an overriding duty to disclose? Two of the American cases which speak of breach of confidence in fact allow disclosure on the grounds of a greater duty, using the language of qualified privilege[145].

D. Privacy

Despite studies designed to establish the degree to which traditional common law actions protect the right to privacy[146], howsoever defined, it is clear that the development of any such action, failing legislation, can only be slow and haphazard. Even where in Canada such an action has been given a statutory base[147], developments in this area have been disappointingly slow. In the United States there has been a great deal of development of the law of privacy, both upon the basis of statutory recognition of such a right and on common law recognition of a tort action, and certain caselaw concerned with unwarranted disclosure of personal medical confidences has relied on a cause of action based on privacy. In those provinces with legislatively defined actions for breach of

privacy, these statutes may offer some protection in the situation with which we are concerned.

The concept of privacy, and the extent of the domain which legal recognition of privacy is expected to protect, is notoriously difficult to define with any precision[148]. In the United States actions based on illegitimate interference with the plaintiff's privacy have been analyzed by Prosser, who concludes that they fall into four categories[149], possibly representing four distinct causes of action. While these categories have not met with universal approval, they have been generally useful. It is into the third category, the public disclosure of private facts, that the methods of protecting the privacy of the subject's medical and related history falls. Even here, however, the requirements of the action limit its usefulness as a protective measure for unwarranted disclosure of personal medical information. Primary among the required elements of this tort or aspect of the tort of privacy, which limit its usefulness, is the requirement of publication.

The publication contemplated is to a greater degree than is necessarily present in the simple wrongful release of information concerning the plaintiff to a single recipient[150]. Private disclosure, even to a small group, is not actionable as an invasion of privacy. Prosser suggests that recourse for such a disclosure lies in the action for breach of contract or breach of a confidential relationship[151]. Two other requirements must be met before the right of action arises. Firstly, the information disclosed must consist of private facts, not public ones[152]. This poses no real difficulty with regard to determining whether the potential protection afforded by the tort action for privacy is sufficiently broad. Secondly, the disclosure must be of a degree and kind which would be offensive to the reasonable man in the circumstances of the case[153]. Thus, an element of flexibility is maintained. Disclosure that plaintiff suffers from the common cold would not be actionable short of circumstances so unusual as to lead to the conclusion that a reasonable man would find disclosure of such a fact, in those particular circumstances, highly offensive. Thus, it is the degree of publication required that limits the usefulness of this action as a protective device in our circumstances.

This limitation is reflected in those American decisions in which an action in privacy serves as the basis of recovery for disclosure of elements of the plaintiff's medical history. The action is most effective where disclosure is in the commercial press. Thus, where photographs or films are taken, either with or without the subject's consent, but are then used in ways not agreed to by the subject[154], or where consent is never

given[155], and details concerning plaintiff's medical condition are published along with information to identify the plaintiff, such as his name or photograph, an action for breach of privacy will lie. Most recently an action for breach of privacy was allowed where a psychiatrist used his patient's disclosures as the basis for a book, in which plaintiff's identity could be easily determined[156]. Plaintiff was successful despite defendant's allegation that such a decision constituted an unwarranted interference with his right of freedom of speech, and with the alleged scientific value of the publication.

As a series of recent cases has made clear, the right of privacy is protected in the United States by the U.S. Constitution. Thus consideration of whether a particular disclosure is warranted involves constitutional considerations. These do not, however, provide for an ultimate ban on any release of such information but must be weighed against other constitutional values. In Roe v. Ingraham[157], the protection afforded to privacy by the United States Constitution was held not so broad as to invalidate a New York State reporting statute requiring the reporting of the names of all those persons receiving Schedule II drugs. Schedule II drugs are controlled narcotics, and the legislation was a legitimate state attempt to control the illegal trade in such drugs and concomitant drug abuse. The legislation was held constitutional even though the names were placed on computer tape and stored, so long as there was evidence that breach of security regulations contained in the statute was difficult, and would result in a substantial penalty[158].

Four of the Canadian provinces have enacted legislation specifically providing for recognition of a right of privacy. The acts of British Columbia[159], Manitoba[160], and Saskatchewan[161] are similar in scope and fairly detailed in conception. The reference to privacy in the Quebec Charter of Human Rights and Freedoms is declaratory[162].

Two of the provincial acts, specifically that of Saskatchewan and British Columbia, define the statutory tort of violation of privacy as requiring a wilful violation of the privacy of another[163]. This requirement limits their usefulness in our situation. A physician or institution negligently allowing disclosure of confidential information would fall outside the purview of the acts. A physician, institution or insurance company deliberately revealing or acquiring such information would be covered.

Each of the acts provides a broad general definition stating that it is a tort, actionable without proof of damage,

to violate the privacy of another. Release of confidential information would fall within the boundaries of a violation of the right of privacy of another. Each statute gives, in addition to the general definition, examples of acts constituting violations of privacy, and drawn from Prosser's four categories and the American caselaw. The examples are not of any great help to our situation. While the statutes of Manitoba and Saskatchewan provide that use of the letters, diaries or other personal documents of a person is prima facie evidence of a violation of the person's privacy, hospital records are the property of the hospital, while physician's records are the property of the physician. Nonetheless, the kind of disclosure with which we are concerned undoubtedly falls within the general definition and if, where necessary, wilful, would be actionable. Neither Quebec nor Manitoba require a wilful violation. The Manitoba Act speaks instead of "a person who substantially, unreasonably, and without claim of right, violates the privacy of another person..." In what is one of their most interesting aspects, each of the statutes provides that breach of privacy is actionable without proof of damage.

Publication by the press of news, which publication is reasonable in the circumstances, is not actionable. Interestingly, the defence of privilege of the law of defamation is specifically made available in all circumstances. Finally the statutes import the American rule that there can be no recovery for invasions that the ordinary, reasonable man would fail to find offensive[164]. Each of the three statutes in the common law provinces provides that it is a valid defence to an invasion of privacy that the act complained of was committed by a peace officer or public officer acting in the course of his duties.

Thus, the situation we contemplate would give rise to a cause of action under the provincial statutes in question, British Columbia and Saskatchewan limiting recourse to situations of wilful violation. The acts of Manitoba and Saskatchewan detail cumulative remedies including damages, injunction, accounting and delivery up. All three provinces specifically import the rules as to privilege into the domain of an action for breach of privacy. The Manitoba Act provides that evidence obtained in breach of privacy is inadmissible in any civil proceeding[165].

In the Province of Ontario there has been some recognition of an action for breach of privacy involving the appropriation of the name or likeness of another for gain[166]. However, neither in Ontario, nor in the other common law provinces has a common law tort of privacy given signs of incipient development.

While a plaintiff complaining of unwarranted disclosure of confidential information in the provinces of British Columbia, Manitoba or Saskatchewan would be well advised to sue for breach of privacy under statute, a plaintiff in another of the common law provinces should give preference to framing such an action in more traditional terms.

E. Breach of Statute[167]

The existence of a statutory prohibition against disclosure has had a profound effect on the development of American caselaw recognizing a cause of action for unwarranted disclosure of confidential information. In relying upon such statutes, usually to support the contention that disclosure is actionable[168] and occasionally to deny a right of recovery[169], American courts have paid little note to questions of legislative intent, existence of a statutory penalty or to the distinction between a statutory imperative as indicative of negligence and a statutory imperative as the source of a common law duty. Most often, statutes concerned with the confidentiality of personal medical information are viewed by the courts as indicative of a public or legislative policy in support of the maintenance of confidentiality[170]. The use made of such statutes in the United States, and the willingness of Canadian courts to look to statutes in other situations involving civil liability[171], suggests that legislative prohibitions against disclosure of confidential information in the Province of Ontario might well serve as the basis of a successful action based on breach of statute or in negligence[172]. In the U.S. many of the cases continue to come forward on defendant's plea that no cause of action has been stated, and various statutory sources have been used to establish the basis of a right of action.

Indicative of the approach of American courts to the problem of the basis of the cause of action is that taken by the United States District Court (Ohio) in Hammonds v. Aetna Casualty and Surety Company[173]. Faced with defendant's contention that the law recognized no such cause of action, Mr. Justice Connell stated:

This is not the first time, nor will it be the last, that a court, confronted with a unique situation, must, after an unsuccessful search for binding precedent on point, repair to the dictates of public policy to do justice between litigants...[174]

Public policy as to confidentiality of medical communications, he continued, is reflected in three separate sources:

We see this concomitant policy reflected in three separate indicia: the promulgated code of ethics adopted by the medical profession on which the public has a right to rely; the privileged communication statute, which precludes the doctor from testifying in open court; and that part of the State Medical Licensing Statute which seals the doctor's lips in private conversation[175].

Mr. Justice Connell refers to the Hippocratic Oath[176] as well.

This use of various statutory indices of the protected status of communications between physician and client is present, to one degree or another, in most of the American caselaw dealing with this problem[177]. However, it must be noted that, on occasion, despite the existence of statutory text, a cause of action has been refused, and that in at least two cases the existence of a privilege was specifically held not to give rise to a cause of action, but to be a rule of evidence only[178].

In the Province of Ontario at this time, certain existing legislative directives indicate that medical records are to be considered as confidential[179]. Although no privilege exists, any one of these appropriate to the particular circumstances might be relied on by a plaintiff as the basis of an action for breach of statute; as indicative of common law duty or as indicating the standard of care required in the circumstances. The caselaw on the use of statutes in any of these ways remains somewhat confused, making a prediction as to when a given court would so rely difficult, and the effect of such reliance unclear[180].

While many statutes provide for the form and content of records to be maintained by various health institutions, several statutes in particular indicate an obligation to maintain confidentiality. One of the clearest obligations of confidentiality is that implicit in The Health Insurance Act, 1972[181] providing that certain information be supplied by the treating physician in order that payment to the physician may be authorized. The release of the required personal information to the general manager of the scheme is required by the statute[182]. The Act further provides that the release as required by law shall be deemed to be authorized by the insured

person[183] and gives rise to no cause of action[184]. By analogy a plaintiff might argue that any release of similar information in circumstances other than those authorized by statute would give rise to a cause of action, particularly where combined with the principles of the Hippocratic Oath and with the Code of Ethics of the College of Physicians of the Province of Ontario.

A more particular provision, and a somewhat more explicit one, is contained in the regulations under The Mental Hospitals Act[185]. The regulations under the Act specifically provide that "...no person shall have access to the records of a patient..." except in a particular set of circumstances therein detailed. The section further states that the Regulation is to apply "...notwithstanding that any information disclosed under the authority of this section is confidential or privileged and no action shall be instituted against the person who discloses it unless it is made maliciously or without reasonable or probable cause[186]." Disclosure outside of the purview of the section would arguably give rise to a cause of action in the subject. A similar duty not to disclose medical records except in certain specified circumstances is contained in the regulations under The Public Hospitals Act[187].

F. Negligence

Perhaps the most interesting approach to the problem of unwarranted disclosure of confidential medical information was that adopted by Barrowclough, C.J. of the Supreme Court of New Zealand in the case of Furniss v. Fitchett[188]. The facts of the case were as follows. Mr. and Mrs. Furniss were suffering marital difficulties apparently occasioned by an unwarranted belief on the part of Mrs. Furniss that her husband was cruel to her and was trying to "dope" and to poison her. The strains imposed upon the marriage as a result were such as to damage the health of Mr. Furniss as well. Both Mr. and Mrs. Furniss had been consulting the defendant Dr. Fitchett, a general practitioner, over a period of time.

In the spring of 1956 Mr. Furniss visited the defendant. According to the evidence of the defendant, Mr. Furniss was distraught as a result of his marital difficulties and asked the defendant to give him a report on his wife which he might give to his lawyers. This the doctor did, after some reflection and hoping to avoid commitment proceedings against Mrs. Furniss[189]. The whereabouts of this report during the following year are not detailed in the reasons for judgment. However, one year later, during separation proceedings between the spouses, the report was introduced into evidence by the

husband's solicitor. Mrs. Furniss, who had had no previous knowledge of the existence of the report, suffered shock and injury to her health, and brought action against the defendant.

Due to some confusion in the pleading of the case, the trial of the issue did not proceed on plaintiff's allegation that there had been breach of an implied term of confidentiality in the medical contract. Mr. Justice Barrowclough indicates that in his opinion a contract did exist between plaintiff and defendant, and did contain such a clause, despite the fact that defendant's account was being paid by Mr. Furniss on behalf of Mrs. Furniss[190]. Rather, the trial of the issue proceeded on the basis of the tort of negligence, and a jury found for the plaintiff. Defendant moved for judgment on the ground that no cause of action had been revealed. In a carefully reasoned judgment, Barrowclough, C.J. held that defendant owed a duty of care to plaintiff, which duty had been breached in the circumstances, resulting in recoverable damage to the plaintiff.

The Court distinguished the situation at bar from that wherein a report has been given which is deliberately false, giving rise to an action in deceit, and from the kind of false statement which gives rise to an action in defamation[191]. As well, Barrowclough, C.J. distinguished any duty owed to plaintiff, from the duty owed by defendant to the British Medical Society as a result of the Hippocratic Oath or the Code of Medical Ethics, and from any obligation defendant might be under to testify in a court of law[192]. Mr. Justice Barrowclough held that defendant owed plaintiff a duty of care not to release confidential medical information on the basis of the dictum of Lord Atkin in Donoghue v. Stevenson[193]. In so doing he emphasized several factors.

Firstly, a physician stands in a "special and peculiar fiduciary relationship"[194] to his client. Secondly, it was reasonably foreseeable that the report would come to his client's attention at some point and that, in that event, injury to his client's health would result[195]. Nor, he added, is the duty of care owed by a physician to his client satisfied simply because the contents of the report are accurate[196]. The Court held that, in the circumstances of the case, the defendant owed plaintiff a duty "to take reasonable care to ensure that no expression of his opinion as to her mental condition should come to her knowledge[197]."

In concluding, Mr. Justice Barrowclough noted that the duty described in the case at bar was less extensive than that described by the Hippocratic Oath and the Code of Ethics and

that, while not necessary to his decision in the case, in his opinion the general duty to preserve a patient's secrets approximates closely the duty outlined in those two documents[198].

It is submitted that the judgment of the Court in Furniss v. Fitchett is a correct one, and that the duty recognized by Mr. Justice Barrowclough is one which ought to be recognized by the law[198a]. The reference by Mr. Justice Barrowclough to the Hippocratic Oath and to the Code of Medical Ethics is only one example of the way in which a court may utilize public statements as indicative of duties owed and of a standard of care to be met, whether in the form of a legislative imperative, or as indicative of custom and usage. Basing plaintiff's action in negligence avoids many of the problems we have noted with regard to other bases, and provides for the full slate of tortious damages. At the same time, the requirement that there be a determination of the reasonable standard of care in the circumstances of each case, provides an element of flexibility that the courts seem to be searching for.

G. Duty to Disclose

While each of the various forms of action that we have considered comes encumbered with its own arsenal of appropriate defences, we have noted from the outset of our discussion a tendency on the part of all courts to look to the privilege defences particular to the action in defamation as providing an appropriate element of flexibility and balance no matter how the plaintiff has framed his action. It is submitted that such an element of flexibility is appropriate to our problem, although it is not necessarily the case that such a balancing of public and private interests can take place only by a wholesale importation of a complex series of rules from one cause of action to a series of others. Rather, closer scrutiny reveals the existence of similar elements of flexibility in the other bases of action as well. Nor, we might add, need we conclude that rules which provide for disclosure are themselves unacceptable simply because on occasion we may disagree with the result of their application by a particular court[199]. Where then does the ability to balance the interest in disclosure as against the interest in confidentiality lie, in the actions which we have suggested are available to the plaintiff who alleges that confidential communications concerning himself have been made public without his authorization?

Where the action is framed in defamation, flexibility lies in the extensively discussed domain of the rules of absolute and qualified privilege[200], and it is in this context that what we

may call an overriding duty to disclose has received the greatest attention. The fact that such rules have been judicially developed in the context of an action to which truth is an absolute defence, and that therefore the rules of privilege are essentially only engaged when and if the statement complained of contains sufficient falsehood, suggests that such rules would be of a certain stringency and not inappropriate to import into other domains, if necessary.

Where the action is framed in breach of contract[201], the law knows no defence amounting to a plea that, for overriding policy reasons, defendant found it necessary to breach the contract, except to the extent such is, on occasion, the implication of a defence of frustration[202] or where the contract is an illegal one. However, where an explicit term of a contract provides for confidentiality, while one of the contracting parties is under an independent and overriding obligation to disclose[203], whether arising out of statute or by common law, it is most likely that the courts would conclude either that any such clause is void as against public policy, or would construe the clause so as to provide for disclosure in the exceptional situation. Thus is the element of flexibility maintained and the balancing of conflicting interests provided for. Where the clause providing for confidentiality is an implied term, having its origin in a fictitious intention attributed to the parties by the court itself, the parameters of the clause as described is able to provide for such overriding considerations in the form of an exception contained in the fictitious clause itself[204]. In either case a court may, if considered necessary, find that the disclosure of a confidential information which would otherwise be actionable as breach of contract, in the circumstances of the case is either required by law or contemplated by the parties and that no cause of action has arisen[205].

Similar considerations appear to apply where the action is brought in breach of confidence. However, as the Younger Committee Report on Privacy pointed out, the law concerning breach of confidence is not yet sufficiently clear to allow us to say with any certainty that disclosure of otherwise confidential information may be made in the public interest[206]. There are indications that such an overriding duty to disclose does exist, although its parameters are yet to be completely drawn.

Where an action is framed in breach of confidence, the balancing of public and private interests, of the duty to maintain confidence and the duty to disclose, finds its expression in the rule that "there is no confidence as to the

disclosure of iniquity[207]." While it is not clear what acts or facts constitute "iniquity", its domain is not limited to information concerning a criminal or civil wrong[208]. That the action in breach of confidence is subject to a defence of overriding necessity of public disclosure may be implied from certain statements of Lord Denning, M.R. in Fraser v. Evans"[209] where he said: "No person is permitted to divulge to the world information which he has received in confidence, unless he has just cause or excuse for doing so[210]." He continued:

I do not look upon the word "iniquity" as expressing a principle. It is merely an instance of just cause or excuse for breaking confidence. There are some things which may be required to be disclosed in the public interest, in which event no confidence can be prayed in aid to keep them secret[211].

Defendant argued that plaintiff had no right to the continuance of an injunction even if the publication of the information in question should prove defamatory, as he intended to justify the publication or to show fair comment on a matter of public interest[212]. This aspect of his argument was successful. Defendant then argued that a similar principle ought to be imported into the action for breach of confidence on the ground that "[t]he plaintiff should not be able to avoid the salutary rule of law in libel by framing the case in breach of confidence[213]." The Court of Appeal chose not to express an opinion on this point, Lord Denning stating somewhat cryptically:

I can well see that there may be cases where it would be wrong to grant an injunction on breach of confidence when it would not be granted on libel: but I can equally well see that there are some cases of breach of confidence which are defamatory, where the court might intervene, even though the defendant says he intends to justify[214].

It should be pointed out that all of the above statements concerning the action for breach of confidence are obiter only, the Court having found that no duty of confidence was owed to the plaintiff in the circumstances of the case[215].

Thus, one of the yet to be clarified elements of the action for breach of confidence is the extent to which the defences

available in a defamation action are available in a breach confidence action[216]. There is, however, clear indication that a plea of duty to disclose is available, and that therefore the court may engage in the act of balancing public and private interests that we have noted with regard to the other forms of action. The extent of any such defence cannot be stated with any certainty. We might surmise, however, that as the courts appear to continue satisfied with the doctrine of absolute and qualified privilege, a similar defence to an action in breach of confidence by whatever name the defence is called, might well grow to approximate the parameters of the privilege defence.

Similar considerations are appropriate where the action is framed in privacy. The privacy acts of Saskatchewan, British Columbia and Manitoba specifically provide that a publication which would otherwise be actionable as a breach of privacy is not so where it is made in accordance with the rules of privilege appropriate to the action in defamation. In including such a defence, the legislature has made a policy decision that the public interest element inherent in the rules of privilege is equally appropriate where the action is framed as breach of privacy, that the interest in disclosure can, in certain circumstances, outweigh the interest in protection of privacy.

In the United States Wade wrote in 1962 that "It is on the subject of privileges that the most difficult single decision regarding the right of privacy must be made[217]." While certain caselaw indicates a wholesale importation of the privilege defence into the realm of the privacy action[218], a similar flexibility is provided for by application of the principle that the invasion of privacy must be "unreasonable" and "unwarranted[219]." Whichever device is chosen, courts are free to balance the interest in disclosure against the interest in the maintenance of confidentiality.

Presumably, the same balancing of interest may be required where there is a statutory prohibition against disclosure, whether the action is framed as one of breach of statute per se or whether the statutory provision is put forward as relevant to an action in negligence. It is not uncommon to find statutes existing side by side wherein one requires disclosure of confidential information, while the other provides that such information be kept in confidence. Reconciliation of two such texts is primarily a question of statutory interpretation, an attempt to read the texts so as to be able to deny any conflict or contradiction between them[220]. However, the rules of the action for breach of statute, as well as the rules of the action in negligence where statutory duty or standard is pleaded, are sufficiently flexible so as to allow any court to give effect to

what it sees as an overriding of disclosure[221]. Similar flexibility is provided by all of the elements of the tort of negligence, and specifically by the necessity to determine the standard of care in all the circumstances of the case[222].

It appears that no matter how the action is framed, it is possible for the defendant to put forward a defence which in fact is an allegation that in the circumstances he was subject to an overriding duty to disclose. What circumstances have triggered judicial recognition of such an overriding duty in the past? In Simonsen v. Swenson[223], an early case which proceeded on the basis of breach of statutory duty, the Court gave considerable thought to the limits which ought to be imposed on the duty of confidence. In that case, defendant had revealed to a hotel keeper that one of the guests was suffering from a "contagious disease."

Is such a rule of secrecy, then, subject to any qualifications or exceptions? The doctor's duty does not necessarily end with the patient; for, on the other hand, the malady of his patient may be such that a duty may be owing to the public and, in some cases, to other particular individuals. Recognition of that fact is given by the statutes in this state...

When a physician, in response to a duty imposed by statute, makes disclosure to public authorities of private confidences of his patient, to the extent only of what is necessary to a strict compliance with the statute on his part, and when his report is made in the manner prescribed by law, he of course has committed no breach of duty toward his patient, and has betrayed no confidence, and no liability could result. Can the same privilege be extended to him in any instance in the absence of an express legal enactment imposing upon him a strict duty to report?...

No patient can expect that if his malady is found to be a dangerously contagious nature he can still require it to be kept secret from those to whom, if there was no disclosure, such disease would be transmitted. The information given to a physician by his patient, though confidential, must, it seems

to us, be given and received subject to the qualifications that if the patient's disease is found to be a dangerous and so highly contagious or infectious a nature that it will necessarily be transmitted to others unless the danger of contagion is disclosed to them, then the physician should, in that event, if no other means of protection is possible, be privileged to make so much of a disclosure to such persons as is necessary to prevent the spread of the disease[224].

The Court went on to hold that the rules of privilege appropriate to the action in defamation applied to any such disclosure[225].

American courts have recognized an overriding duty to disclose where a physician was requested by the client's employer to clarify the underlying cause of recurring illnesses that the doctor had certified at the patient's request[226] and where the client has put his physical condition in issue in litigation[227]; and have postulated that there may be additional situations wherein the physician has a right, or a duty, to disclose[228]. Furthermore, in certain instances, liability has been imposed for a failure to disclose, where the failure results in injury to the subject or to a third party[229].

Conclusion:

The common law provides several remedies sufficiently broad to sustain an action for compensation by the plaintiff who alleges an unwarranted disclosure of personal information[230]. These remedies are available whether disclosure is by the original confidant, usually a treating physician, by an institutional recipient of that information such as a hospital, or employer, or third party payer or by any person who actively induces breach of confidence, such as an insurance company or investigator[231]. Several of these forms of action suffer from requirements which make them less than ideal as the basis of a remedy for the situation with which we are concerned. An action based in negligence or an action based on one of the existing privacy acts provides, in our opinion, the greatest chance of meaningful recovery.

Two major drawbacks to private litigation as a deterrent device in this domain must be mentioned. Confidential medical information is a valuable commodity. Therefore, except where disclosure is authorized by the subject or by law, measures to

deter unwarranted disclosure must be designed with sufficient effect so as to outweigh the economic attraction of participating in such disclosure.

Private litigation by the subject of any such disclosure is hardly the optimal mechanism of deterrence for two reasons. Firstly, the subject of an unwarranted and unauthorized disclosure is unlikely to know, in the great majority of cases, that such disclosure has occurred. Secondly, even where the subject becomes aware that disclosure has taken place, the nature of the damages may well be such as to fall within the domain of damages poorly compensated, or simply not compensated, by the law. Even where compensable, the costs of a private action to so recover are likely to make such an action uneconomic. Rather, thought must be given to legislative control of abuses in this domain.

NOTES TO TEXT

1. Trial of the Duchess of Kingston (1776) 20 Howell's State Trials 355.
2. Ibid. p. 573.
3. Ibid.
4. Ibid.
5. See page 48 seq.
6. AB v. CD (1851) 14 Dunlop 177.
7. Ibid. p. 179.
8. Ibid. p. 180.
9. Ibid.
10. Ibid. In the same vein Lord Ivory: "If it could ever have been doubted that such a confidential relation subsists between a medical man and his employer, I think it high time that such a doubt should now be set at rest for ever." (p. 180)
11. Supra at note 1.
12. The Code of Civil Procedure of the Province of Quebec provides for a testimonial privilege in civil matters. Article 308 C.C.P.
13. See for example: Broad v. Pitt [1928] M & M 233 at 234: "The privilege is an anomaly, and ought not to be extended; it does not exist in the case of clergymen or medical men; however important the communications to them may be, they are compellable to disclose them..." (per Best, C.J.); Greenough v. Gaskell (1833) 1 MY & K 101 at 103: "...it may not be very easy to discover why a like privilege has been refused to others and especially to medical advisers." (per Lord Chancellor Brougham); Anderson v. Bank of British Columbia (1876) 2 C.A. (Chancery Division) 644 at 650, 651.
14. (1881) 17 C.A. (Chancery Division) 675.
15. Ibid. at p. 681.

16. See Elliott, "Medical Evidence" [1968] Chitty's L.J. 343.
17. J.L. Baudouin, Secret professionnel et droit au secret dans le droit de la preuve, Paris, 1965.
18. Regina v. Potvin (1972) 16 C.R.N.S. 233 at 238, but see contra: Regina v. Hawke (1974) 3 O.R. (2d) 210 at 226.
19. Supra note 1.
20. Canada Evidence Act, R.S.C. 1970, C.E.-10.
21. See for example Regina v. Burgess [1974] 4 W.W.R. 310 where Cashman, J. finding that statements made by the accused to a psychiatric social worker and to a psychiatrist were not privileged on the authority of, among other cases, Wheeler v. Le Marchant, stated "I must confess that I, too, am unable to appreciate the distinction between a doctor and patient and a solicitor and client. However, the law appears to me to be that such a distinction exists and that being so I must give effect to it. Accordingly I find that what the accused said to the doctor is not inadmissible on the ground of privilege." (at p. 314) See contra: Regina v. Potvin (1972) 16 C.R.N.S. 233 denying any privilege and justifying the necessity for such disclosure before the court.
22. (1974) 3 O.R. (2d) 210.
23. Ibid. p. 226. While the sentiments voiced by Mr. Justice Haines are ones to which we are sympathetic, he chose an extremely unfortunate set of circumstances in which to express them. Regina v. Hawke concerned a charge of murder. The primary crown witness had a long history of mental disturbance accompanied by hallucinations. The psychiatric evidence, called by the accused, but excluded by Mr. Justice Haines, was to the effect that the testimony of the crown witness could not be considered competent. Even were there such a privilege before the criminal law courts of Canada, it seems clear on the facts of the case that the crown witness would have willingly waived any claim to the privilege. See "Exclusion of Relevant and Admissible Evidence" (1964) 13 Chitty's L.J. 41 McLachlin "Confidential communications and the law of Privilege" (1977) 11 U.B.C.L.R. 266.
24. Regina v. Hawke (1975) 29 C.R.N.S. 1.

25. McLachlin, *ibid.* note 23, at p. 270-271.
26. 21 R.F.L. 46.
27. *Ibid.* p. 47.
28. *Ibid.*
29. *Ibid.* p. 48.
30. *Ibid.* p. 49.
31. *Ibid.* p. 50.
32. Bill C-122, An Act to Amend the Canada Evidence Act (Privileged Communications).
 1. The Canada Evidence Act is amended by adding, immediately after section 12 thereof the following heading and sections.

PRIVILEGED COMMUNICATIONS

- 12A. (1) A person, whether or not a party, has a privilege to refuse to disclose and to prevent a witness from disclosing a communication if he claims the privilege and the judge finds that:
- (a) the communication was a penitential communication and,
 - (b) the witness is the penitent or the priest, and
 - (c) the claimant is the penitent, or the priest making the claim on behalf of an absent penitent.
- (2) In this section,
- (a) "priest" means a priest, clergyman, minister of the gospel or other officer of a church or of a religious denomination or organization, who in the course of its discipline or practice is authorized or accustomed to hear, and has a duty to keep secret, penitential communications made by members of his church, denomination or organization;

- (b) "penitent" means a member of a church or religious denomination or organization who has made a penitential communication to a priest thereof;
- (c) "penitential communication" means a confession of culpable conduct made secretly in confidence by a penitent to a priest in the course of discipline or practice of the church or religious denomination or organization of which the penitent is a member.

12B. (1) Except as provided by subsections (2), (3), (4) and (5) of this section, a person whether or not a party, has a privilege in an action to refuse to disclose, and to prevent a witness from disclosing, a communication, if he claims the privilege and the court finds that,

- (a) the communication was a confidential communication between the patient and physician, and
- (b) the patient or the physician reasonably believed the communication to be necessary or helpful to enable the physician to make a diagnosis of the condition of the patient or to prescribe or render treatment therefor, and
- (c) the witness

- (i) is the holder of the privilege, or

- (ii) at the time of the communication was the physician or a person to whom disclosure was made because reasonably necessary for the transmission of the communication or for the accomplishment of the purposes for which it was transmitted, or

- (iii) is any other person who obtained knowledge or possession of the communication as a result of an intentional breach of the physician's duty of nondisclosure by the physician or his agent or servant, and

- (d) the claimant is the holder of the privilege or a person authorized to claim the privilege for him.
- (2) There is no privilege under this section as to any relevant communication between the patient and his physician,
 - (a) upon an issue of the patient's condition in an action to commit him or otherwise place him under the control of another or others because of alleged mental incompetence, or in an action in which the patient seeks to establish his competence or in an action to recover damages on account of conduct of the patient which constitutes a criminal offence, or
 - (b) upon an issue as to the validity of a document as a will of the patient, or
 - (c) upon an issue between claiming by estate or intestate succession from a deceased patient.
 - (3) There is no privilege under this section in an action in which the condition of the patient is an element or factor of the claim or defense of the patient or of any party claiming through or under the patient or claiming as a beneficiary of the patient through a contract to which the patient is or was a party.
 - (4) There is no privilege under this section as to information which the physician or the patient is required to report to a public official or as to information required to be recorded in a public office, unless the statute requiring the report or record specifically provides that the information shall not be disclosed.
 - (5) No person has a privilege under this section if the court finds that sufficient evidence, aside from the communication, has been introduced to warrant a finding that the services of the physician were sought or obtained to enable or aid anyone to commit or to plan to commit a crime or a tort, or to escape detection or apprehension after the commission of a crime or a tort.

(6) A privilege under this section as to a communication is terminated if the court finds that any person while a holder of the privilege has caused the physician or any agent or servant of the physician to testify in any action to any matter of which the physician or his agent or servant gained knowledge through the communication.

(7) In this section,

- (a) "patient" means a person who, for the sole purpose of securing preventive, palliative or curative treatment, or a diagnosis preliminary to such treatment, of his physician or mental condition, consults a physician, or submits to an examination by a physician;
- (b) "physician" means a person authorized or reasonably believed by the patient to be authorized, to practice medicine in the state or jurisdiction in which the consultation or examination takes place;
- (c) "holder of the privilege" means the patient while alive and not under guardianship or the guardian of the person of an incompetent patient or the personal representative of a deceased patient;
- (d) "confidential communication between physician and patient" means such information transmitted between physician and patient, including information obtained by an examination of the patient, as is transmitted in confidence and by means which, so far as the patient is aware, discloses the information to no third persons other than those reasonably necessary for the transmission of the information or the accomplishment of the purpose for which it is transmitted.

12C. No social worker shall be required to disclose any information which he may have acquired in attending a person in a professional character as a social worker and which information was necessary to enable him to aid such person as a social worker: provided

that the court may compel such disclosure if in its opinion the same is necessary to proper administration of justice."

33. [1964] 1 O.R. 361.
34. Ibid. at p. 362.
35. Ibid. p. 363.
36. Ibid. p. 364.
37. Ibid. pp. 364-65.
38. Ibid. p. 365.
39. Ibid. p. 366.
40. [1969] 2 O.R. 857.
41. Ibid. at p. 863.
42. Ibid. Mr. Justice Wright also held the privilege provided by S.21(2) of the Divorce Act inapplicable to any person other than one appointed by the court for the purposes of reconciliation under S.8(1)(b). However, in Shakotko v. Shakotko (1977) 27 R.F.L. 1 Mr. Justice Grant held that S.21(2) renders any communication made in an attempt to reconciliation of marriage to whomever made, privileged in any proceedings. This is in line with a recognition at common law in England of a privilege with regard to communications made in attempts at reconciliation of marriage. See: McTaggart v. McTaggart [1948] 2 ALL E.R. 754; Mole v. Mole [1950] 2 ALL E.R. 328; Pais v. Pais [1970] 3 ALL E.R. 491.
43. McTaggart v. McTaggart [1948] 2 ALL E.R. 754; Mole v. Mole [1950] 2 ALL E.R. 328; Pool v. Pool [1951] 2 ALL E.R. 563; Henley v. Henley [1955] 1 ALL E.R. 590n; Theodoropoulos v. Theodoropoulos [1963] 2 ALL E.R. 772; Slade-Powell v. Slade-Powell (1964) 108 S.J. 1033; Pais v. Pais [1970] 3 ALL E.R. 491. This line of cases may be contrasted with the decision in Garner v. Garner (1920) 36 T.L.R. 196 in which a doctor was compelled to give evidence that his patient suffered from venereal disease despite specific statutory regulations enjoining absolute secrecy.
44. (1977) 27 R.F.L. 1.

45. R.S.C. 1970, C.D-8.
46. Op. cit. note 44 p. 9. See contra: Robson v. Robson [1969] 2 O.R. 857; Cronkwright v. Cronkwright [1970] 3 O.R. 784.
47. (1977) 1 Legal Medical Quarterly 139.
48. Ibid. at p. 142.
49. (1975) 55 D.L.R. (3d) 224. See also 11 U.B.C.L.R. 266.
50. Ibid. at p. 228.
51. Wigmore on Evidence (ed. McNaughton) v. 8 no. 2285 3rd ed.
52. Op. cit. note 56 at p. 229.
53. Ibid. at p. 229. Op. cit. at p. 273.
54. Report on the Law of Evidence, Ministry of the Attorney General, Ontario Law Reform Commission, 1976.
55. Report on Evidence, Law Reform Commission of Canada, Ministry of Supply and Services, Ottawa, 1975.
56. Ibid. "Evidence Code" s.41, p. 30.
57. Ibid. "Commentary" p. 80. Compare Bill C-122 (1964), supra note 32.
58. Ibid.
59. Op. cit. note 49, p. 145-46.
60. For other commentators both in favour and against allowing a privilege see: Hammelman, "Professional Privilege: A Comparative Study" (1950) 28 Can. Bar Rev. 750; J.L. Baudouin, "Le Secret Professionnel du Médecin - Son Contenu - Ses Limites," (1963) 41 Can. Bar Rev. 492; S. Freedman, "Medical Privilege" (1954) 32 Can. Bar Rev. 1; W.C.J. Meredith, "Medical Privilege: A Good or Bad Law?" 19 R. du B. 261; _____, "Exclusion of Relevant and Admissible Evidence - Doctors and Priests" (1964) 13 Chitty's L.J. 41; L.E. Rozovsky and S.N. Akhtar, "Should Psychiatric Communication Be Privileged?" (1977) 1 Legal Medical Quarterly 115.

61. (1828) N.Y. Rev. Stat. 406.
62. Rozovsky and Akhtar, op. cit. note 55.
63. See cases cited at p. 49 note 78 ff.
64. Fahey v. United States (1955) 18 F.R.D. 231; Ballard v. Pacific Greyhound Lines (1946) 170 P. 2d 465.
65. In Re Lifschutz (1970) 467 P. 2d 557.
66. See People v. Sigal (1965) 235 Cal. App. 2d 449; United States v. Carr (1970) 437 F. 2d 662.
67. See infra p. 27-34.
68. See D. v. D. (1969) 260 A. 2d 255.
69. See Hampton v. Hampton (1965) 405 P. 2d 549.
70. In Re Warrington (1951) 100 N E 2d 170.
71. Kendal v. Gore Properties, Inc. (1956) 236 F. 2d 673; Heir v. Farmers Mutual Fire Insurance Company (1937) 67 P. 2d 831.
72. Newell v. Newell (1956) 303 P. 2d 839.
73. Heuston v. Simpson (1888) 17 N.E. 261.
74. "Right of Physician, Notwithstanding Physician-Patient Privilege, to give Expert Testimony Based on Hypothetical Question" 64 A.L.R. 2d 100.
75. Ibid.
76. For an excellent study of evidentiary privileges in the Province of Quebec see: J.-L. Baudouin, Secret Professionnel et Droit au Secret Dans Le Droit de la Preuve, Librairie General de Droit et de Jurisprudence, Paris, 1965.
77. J.-L. Baudouin, "Le Secret Professionnel du Médecin - Son Contenu - Ses Limites", (1963) 41 Can. Bar Rev. 491 at 492.
78. Ibid. at p. 494; Medical Art (1909) 9 Edw. VII, C.55, S.1.

79. Art. 322 was then renumbered, becoming article 308 C.P.C.
80. Baudouin, op. cit. note 77 at p. 497; Mutual Life Insurance Co. of New York v. Jeannotte-Lamarche (1935) 59 B.R. 510, "Considérant que la loi médicale de Québec est une loi publique et que la disposition de cette loi qui a trait au secret professionnel est aussi d'intérêt public." (at p. 515)
81. Ibid. Baudouin at p. 492.
82. Ibid. at p. 510.
83. P.-A. Crépeau, "Relations entre l'hôpital, le médecin et la presse." Unpublished conference, 27 April 1956 cited in (1969) 29 R. du B. 589 at p. 592.
84. Le Roi v. Z. [1947] B.R. 457.
85. [1928] S.C.R. 125.
86. See French v. Smith [1923] 3 D.L.R. 902.
87. Halls v. Mitchell [1928] S.C.R. 125 at 133.
88. Ibid. at 134.
89. Ibid. at p. 140.
- 89a. MacIntosh v. Dun [1908] A.C. 390.
90. Ibid. at p. 146.
91. Ibid.
92. Ibid. at p. 130.
93. Ibid. at p. 143.
94. Ibid. at p. 136.
95. Ibid.
96. [1925] 1 D.L.R. 734. For a more recent application of the defence see McLoughlin v. Kutasy (1979) 26 N.R. 242 (S.C.C.).

97. See for a more recent example Foran v. Richman (1976) 10 O.R. (2d) 634.
98. Op. cit. note 96 at p. 740.
99. For a case framed in defamation and in breach of statute see Munzer v. Blaisdell (1944) 49 N.Y.S. 2d 915. For actions framed in defamation see: Shoemaker v. Friedberg (1947) 183 P. 2d 318 (statement to plaintiff, her mother and her landlady that plaintiff suffered from gonorrhoea held qualifiedly privileged as made by a person with an interest to a person with a similar interest and where the relationship between the two interested parties gives good cause to suppose the communicant's motive innocent and where no malice had been proved). Also Kenney v. Gurley (1923) 26 A.L.R. 813; Collins v. Oklahoma State Hospital (1916) 7 N.R. 895. For actions where qualified privilege was found to be destroyed by malice see Alpin v. Morton (1871) 21 Ohio 536 (allegation of pregnancy in unmarried sixteen-year-old); Beatty v. Baston (1932) 13 Ohio 481 (allegation of gonorrhoea in plaintiff made to plaintiff's employer).
100. (1958) 73 A.L.R. 2d 315. See annotation "Libel and Slander: Privilege of Statements by Physician, Surgeon or Nurse Concerning Patient" (1958) 73 A.L.R. 2d 325.
101. Ibid. p. 320.
102. Ibid. p. 321.
103. Ibid. p. 323.
104. Ibid.
105. Ibid. p. 324.
106. Ibid.
107. Ibid. p. 322.
- 107a. J.W. Wade "Defamation and the Right of Privacy" (1962) 14 Vanderbilt Law Rev. 1093 at 1112.
108. Ibid. p. 320-321.
109. (1920) 9 A.L.R. 1250.

110. Ibid. at p. 1253. In Canada see the language of Mr. Justice Duff in Halls v. Mitchell quoted in the text accompanying note 95.
111. See Hofmann v. Blackmon 241 So. 2nd 752; Wojcik v. Aluminum Co. of America 183 N.Y.S. 2d 351; Davis v. Rodman 227 S.W. 612.
112. (1974) 529 P. 2d 553.
113. C.J. Roedersheimer, "Action for Breach of Medical Secrecy Outside the Courtroom" (1967) Univ. of Cincinnati L.R. 103 at 106. See also Furniss v. Fitchett [1958] N.Z.L.R. 396 at 401: "No Doubt [attorney for plaintiff] elected to base his claim in tort rather than in contract, for the reason that he hoped to recover exemplary damages...". Report of the Committee on Privacy, London 1972 Cmd. 5012 at p. 294: "...an invasion of privacy which has taken place once and for all (and where therefore an injunction would have no point) and which has only caused the plaintiff annoyance or embarrassment is not effectually protected by the contractual remedy..."
- 113a. For cases implying such terms, or recognizing that such is possible see: Pollard v. Photographic Co. (1889) 40 Ch. D. 345; Argyll v. Argyll, [1967] Ch. 302 at 322.
114. In Furniss v. Fitchett, op. cit. note 113, Barrowclough, C.J. of the Supreme Court considered an action brought by Mrs. Furniss, against her treating physician Fitchett. The behaviour complained of involved the release to the husband of a certificate indicating a diagnosis of Mrs. Furniss' condition as paranoia. The certificate was destined for use by the husband's solicitor and was in fact so used one year later in a matrimonial dispute. Mrs. Furniss suffered physical injury as a result of the sudden disclosure of such a diagnosis of which she had not been previously aware. The case proceeded as an action in tort due to the way in which it was pleaded (see supra note 14) but Barrowclough, C.J. made clear, although obiter, remarks that an action would lie in contract: "...because of the way this action was conducted, I am not concerned with any duty which might have been owed by the doctor if he stood in any contractual relationship to his patient. Even though it be obiter, I feel justified in expressing my view that there was here a contractual relationship, and I can scarcely doubt that, if it had been put to it, the jury would have found on the evidence that, in that contract,

there was an implied term of confidentiality, and that there had been a breach of it." (at p. 400) See also Quarles v. Sutherland 389 S.W. 2d 249 at 252 in which the Supreme Court of Tennessee held: "We think that the only possible sounding of this lawsuit would be under allegations that there was an implied contract between the parties that the results of the examination would remain confidential or, in the alternative, slander, assuming the statements were untrue. However, proceedings along this line of reasoning could not be considered in this case as the declaration makes clear that Dr. Sutherland was not the plaintiff's doctor nor did she at any time attempt to compensate him for his services... As concerns slander, there were no factual allegations that the statements were untrue or slanderous in nature." (per White J.)

115. See *infra* p. 48 seq.
116. *Ibid.*
117. (1965) 243 F. Supp. 793.
118. *Ibid.* at p. 801; See also Horne v. Patton 287 So. 2nd 824 at 831-32.
119. Report of the Committee on Privacy, Kenneth Younger, Chairman, 1972, London, Cmnd. 5012.
120. *Ibid.* p. 294.
121. *Ibid.*
122. (1975) 55 D.L.R. (3d) 224.
123. (1849) H and T 1. See also the case quoted therein at p. 25 (unreported). "This was the opinion of Lord Eldon, expressed in the case of Wyatt v. Wilson in the year 1820, respecting an engraving of George III, during his illness; furnished by Mr. Cooper, he said: "If one of the King's physicians had kept a diary of what he had heard and seen, this Court would not in the King's lifetime, have permitted him to print or publish it."
124. By way of example see cases cited by Jones, *infra* note 26, and Forrai, *infra* note 125.
125. Garreth Jones, "Restitution of Benefit's Obtained in Breach of Another's Confidence," (1970) 86 Law Quarterly

Rev. 463 at 464; George Forrai, "Confidential Information - A General Survey" Sydney Law Rev. 382.

126. Ibid. at p. 466.

127. Seager v. Copydex Ltd. (No. 2) [1969] 1 W.L.R. 809.

128. This is the solution of the above case. For a critique see Forrai op. cit. note 125 at p. 387.

129. Forrai, op. cit. at p. 385. Also U.S. Lift Slab Corp. v. C.D. Wales Co. 113 U.S. Patent Quarterly 228 at 229 holding that the following criteria are present where the relationship is confidential:

- "1. A must trust B, not necessarily to do or not to do a specific thing, but in a real positive way related to B's conduct insofar as it may affect A. The most common and perhaps the most extreme example is the relationship of husband and wife, wherein each trusts the other, nearly always silently, to be loyal, honest, and solicitous of the others well-being.
2. B must know of that trust, or the circumstances must be such as to make reasonably inexcusable a lack of such knowledge and he must accept the trust if not expressly, then by acquiescence or conduct reasonably justifying A in believing that B knows of A's trust in him and that B accepts or has accepted the ethical responsibility of that trust.
3. Out of the synchronism of intent, interests, and motives thus established, and all the enveloping and involved facts, a duty of loyalty must be begotten to rest on B, a duty which may be too broad or general for specific definition but which, nevertheless, must be determinable in relation to any specific conduct or act or omission."

It is submitted that the courts would have no difficulty, and have had no difficulty in the past, in characterizing the physician-client relationship and meeting this or any similar criteria.

130. Ibid. p. 383-385.

131. [1967] Ch. 302.

132. Ibid. p. 322. Although the Court held that it is clear that a breach of confidence arising out of contract or property would be restrained.
133. Ibid. p. 322. See also Pollard v. Photographic Co. (1889) 40 Ch. D 345.
134. Ibid. p. 332.
135. Ibid. p. 333.
136. Ibid. p. 332.
137. Ibid. p. 328.
138. Ibid. p. 330.
139. "There comes then, of course, the practical difficulty of deciding what communications between husband and wife should be protected.... Such a difficulty would be a very good reason for not distinguishing between confidential and other information in the giving of evidence in legal proceedings. There quick decisions have to be made in the course of the giving of the evidence itself, and to be practical and effective a rule would have to be readily and quickly applicable." (at p. 330)
140. (1975) 55 D.L.R. (3d) 224.
141. Ibid. at p. 230. See also Bell v. University of Auckland [1969] N.Z.L.R. 1029.
142. See Clark v. Geraci (1960) 208 N.Y.S. 2d 564; Felis v. Greenberg (1966) 273 N.Y.S. 2d 288; Alexander v. Knight (1962) 177 A 2d 142; Berry v. Moench (1958) 73 A.L.R. 2d 315; Hammonds v. Aetna Casualty and Surety Co. (1965) 237 F. Supp. 96; 243 F. Supp. 793 (motion for rehearing).
143. Smith v. Driscoll (1917) 162 P. 572 at 572.
144. Younger Report, op. cit. at p. 297.
Jones, op. cit. at p. 472.
145. Clark v. Geraci, op. cit. note 142; Berry v. Moench, op. cit. note 142.
146. Classic among these is, of course, the seminal article by Brandeis and Warren, "The Right to Privacy" (1890) 4

- Harvard L.R. 193. More recently see Peter Burns, "The Law and Privacy: The Canadian Experience" (1976) 54 Can. Bar Rev. 1.
147. The Privacy Act, 1974, 1973-74 S.S., c.80 Privacy Act, 1968 S.B.C., c.39; Privacy Act, 1970 S.M., c.74; Quebec Charter of Human Rights and Freedoms, 1975 S.Q., c.6.
148. For a recent review of definitions see Burns, op. cit. note 47.
149. William L. Prosser, Law of Torts, West Publishing Co., 1971 at p. 804. These include appropriation, intrusion, public disclosure of private facts and placing the plaintiff in a false light in the public eye.
150. "The disclosure of private facts must be a public disclosure, and not a private one; there must be, in other words, publicity." Prosser, *ibid.* p. 810.
151. *Ibid.* For a discussion of these actions see *supra* p. 34 and p. 36.
152. *Ibid.* p. 811.
153. *Ibid.*
154. Feeney v. Young (1920) 181 N.Y.S. 481 (Film of caesarean section taken with consent for exhibition to medical societies, but used in commercial distribution); Griffin v. Medical Society of State of New York (1939) 11 N.Y.S. 2d 109 (photographs of plaintiff's "saddle nose" used in article in medical journal).
155. Barber v. Time, Inc. (1942) 159 S.W. 2d 291; Horne v. Patton (1974) 287 S. 2d 824.
156. Doe v. Roe (1977) 400 N.Y.S. 2d 668. See also the obiter remarks in Hammonds v. Aetna Casualty and Surety Co. (1965) 243 F. Supp. 793 at 801-802. "If a doctor should reveal any of these confidences, he surely effects an invasion of the privacy of his patient. We are of the opinion that the preservation of the patient's privacy is no mere ethical duty upon the part of the doctor; there is a legal duty as well."
157. Roe v. Ingraham (1975) 403 F. Supp. 931, (1977) 429 U.S. 589.

158. Ibid. "The receiving room (for copies of prescription forms required by the statute to be submitted, and which indicate the patient's name) is surrounded by a locked wire fence and protected by an alarm system. The computer tapes containing the prescription data are kept in a locked cabinet. When the tapes are used, the computer is run "off-line" which means that no terminal outside of the computer room can read or record any information." (p. 594)
159. Privacy Act, 1968 S.B.C., c.39.
160. Privacy Act, 1970 S.M., c.74.
161. The Privacy Act, 1974, 1973-74 S.S., c.80.
162. 1975 S.Q., c.6. Quebec civil law, particularly article 1053 C.C. is universally thought to be available for actions we would describe as alleging invasion of privacy. For the seminal case see Robbins v. C.B.C. (1957) 12 D.L.R. (2d) 35.
163. Defined in Davis v. McArthur as "...intentionally, knowingly and purposefully without justifiable excuse...as distinct from a negligent act." (1970) 10 D.L.R. (3rd) 250 at 253.
164. For an application of this principle under the British Columbia Act see Davis v. McArthur (1970) 10 D.L.R. (3d) 250; rev'd, (1971) 17 D.L.R. (3d) 760.
165. S.M. 1970, c.74, s.7.
166. Krouse v. Chrysler Canada Ltd. (1974) 1 O.R. (2d) 225; Racine v. C.J.R.C. Radio Capitale Ltée (1978) 80 D.L.R. (3d) 441.
167. The general requirements for an action based on breach of statute include violation of the statute, injury of the type the statute was designed to prevent, a plaintiff who falls clearly within the class of persons whose protection was contemplated and a causal connection. (See Fleming, The Law of Torts, (4th ed. 1971) p. 121; Prosser, Torts, (4th ed. 1971) p. 190; Linden, Canadian Negligence Law, (1972) p. 101; Clerk and Lindsell, Torts, (1975) p. 908.) However, any attempt to predict when a court will look to a statute as giving rise to a cause of action can, at best, catalogue the elements a court would consider. These include legislative intention and

existence and severity of a penalty. See generally, the discussion by Linden at p. 85 seq. Nor is the effect of a breach of statute any more clear than when a statutory imposition of a duty will be given civil sanction. (Linden, p. 112 seq.)

168. Berry v. Moench (1958) 73 A.L.R. (2d) 315 at 320.
169. Quarles v. Sutherland (1965) 359 S.W. (2d) 249 at 251.
170. See Munzer v. Blaisdell (1944) N.Y.S. 2d 915; Horne v. Patton (1974) 287 So. 2d 824.
171. By way of example Jordon House Ltd. v. Menow & Honsberger (1973) 38 D.L.R. (3d) 105, Horsley v. MacLaren (1972) 22 D.L.R. (3d) 545.
172. See *infra* p. 49 ff.
173. (1965) 243 F. Supp. 793.
174. *Ibid.* p. 796.
175. *Ibid.* p. 797.
176. "Whatever in connection with my professional practice or not in connection with it I see or hear in the life of men which ought not to be spoken abroad I will not divulge as recommending that all such should be kept secret."
177. See by way of example: Munzer v. Blaisdell (1944) 49 N.Y.S. 2d 915 at 917 where a state statute required that state mental hospitals maintain records and keep them confidential. The court held that "...where the statutory duty is violated, the patient is entitled to redress; for it is well settled that, where a positive duty is imposed by statute, a breach of that duty will give rise to a cause of action for damages on the part of the person for whose benefit the duty was imposed; and, in such case, if the statute itself does not provide a remedy, the common law will furnish it." Horne v. Patton (1974) 287 So. 2d 824 at 829: "When the wording of Alabama's state licencing statute is considered alongside the accepted precepts of the medical profession itself, it would seem to establish clearly that public policy in Alabama requires that information obtained by a physician in the course of a doctor-patient relationship be maintained in confidence, unless public interest or the

private interest of the patient demands otherwise." (Alabama does not have a statute providing for a testimonial privilege.) "It thus must be concluded that a medical doctor is under a general duty not to make extra-judicial disclosures of information acquired in the course of the doctor-patient relationship and that breach of that duty will give rise to a cause of action."; Berry v. Moench (1958) 73 A.L.R. 2d 315 at 320-21: "That relationship [doctor-patient] is among those with respect to which it is the policy of the law to encourage confidence. This policy is expressed in Sec. 78-24-8 U.C.A. 1953 which provides, inter alia, that a physician cannot be examined as to any information acquired in attending his patient... It is our opinion that if the doctor violates that confidence and publishes derogatory matter concerning his patient, an action would lie for any injury suffered." Hague v. Williams (1962) 181 A. 2d 345 at 348 in the context of no legislative recognition of a testimonial privilege the court said: "...the same philosophy does not apply with equal rigor to non-testimonial disclosure. The above ethical concepts, although propounded by the medical profession under its own code, are as well expressive of the inherent legal obligation which a physician owes to his patient; Schaffer v. Spicer (1974) 215 N.W. 2d 134 at 136: "The above statute (testimonial privilege statute) imposes a duty upon a physician or other healing practitioner to keep confidential or privileged, information gained while in professional attendance of a patient. If a practitioner of the healing art breaches that duty by making any unauthorized disclosure of confidential information he may be liable to the patient for resulting damages." Clark v. Geraci (1960) 208 N.Y.S. 2d 564 at 567: "...while no principle of common law is violated disclosure is plainly reprehensible as indicated by the statutory law in this state, accepted usage and the Hippocratic Oath... Other jurisdictions have recognized that a disclosure may be actionable...I believe that the cause of action should also be recognized in this state because the duty of secrecy is implied by our statutory law and widely conceived in the doctor-patient relationship."

Quarles v. Sutherland (1965) 389 S.W. 2d 249 at 251 holding that a licencing statute providing that breach of confidence was unprofessional conduct was a "merely administrative provision" setting out standards "merely ethical in nature" and not enforceable by law.

178. Curry v. Corn (1966) 277 N.Y.S. 2d 470 at 471: "...this Court is inclined to the view that the Legislature in enacting [the statutory privilege] did not intend to create a cause of action against the physician who may disclose information without consent of the patient but intended merely to govern the reception of evidence." Also Quarles v. Sutherland, *ibid.* at p. 252: "the petitioner is seeking to base a cause of action on a rule of evidence."
179. See Health Disciplines Act, 1974, S.O. 1974, c.47, as amended by S.O. 1975, c.63; O.R. 577-75, s.26 defining unprofessional conduct as "giving information concerning a patient's condition or any professional services performed for a patient to any person other than the patient without the consent of the patient unless required to do so by law."
180. For recent discussion of the state of Canadian law in this area see Linden, Canadian Negligence Law, Chapter 4 p. 82 seq. and authorities therein cited.
181. S.O. 1972, c.91 as amended by S.O. 1974, c.60 and c.86.
182. *Ibid.* s.33(1).
183. Sec. 33(2).
184. Sec. 33(3).
185. R.S.O. 1970, c. 270; R.R.O. 1970, Reg. 578, s.3(2).
186. *Ibid.* s.3(6).
187. R.R.O. 1970, Reg. 729, s.48(5). See for another explicit prohibition on publication except as specifically authorized the Venereal Diseases Prevention Act, R.S.O. 1970, c.479, s.13.
188. [1958] N.Z.L.R. 396.
189. Quoted as follows at p. 398 on the judgment:

"Mrs. Phyllis C.L. Furniss
32 Mornington Road

21.5.56

The above has been attending me for some time and during this period I have observed several things:

(1) Deluded that her husband is doping her.

(2) Accuses her husband of cruelty and even occasional violence.

(3) Considers her husband to be insane and states that it is a family failing.

On the basis of above I consider she exhibits symptoms of paranoia and should be given treatment for same if possible. An examination by a psychiatrist would be needed to fully diagnose her case and its requirements.

Yours Faithfully,
A.J. Fitchett"

190. Ibid. p. 399-400. "Even though it be obiter, I feel justified in expressing my view that there was here a contractual relationship and I can scarcely doubt that, if it had been put to it, the jury would have found on the evidence that, in that contract, there was an implied term of confidentiality, and that there had been a breach of it. No doubt [plaintiff's attorney] elected to base his claim in tort rather than in contract, for the reason that he hoped to recover exemplary damages, and I do not criticize his tactics in the least." (p. 400-401)
191. Ibid. p. 401.
192. Ibid.
193. [1932] A.C. 562 at 580.
194. Furniss v. Fitchett, op. cit. at p. 404.
195. Ibid. p. 403.
196. Ibid. "I have not forgotten that the certificate was true and accurate, but I see no reason for limiting the duty to one of care in seeing that it is accurate. The duty must extend also to the exercise of care in deciding whether it should be put in circulation in such a way that it is likely to cause harm to another."
197. Ibid. p. 404.
198. Ibid.
- 198a. See Prosser, Law of Torts, (3rd ed. 1964) at p. 332: "The assertion that liability must...be denied because defendant bears no duty to plaintiff begs the essential question - whether the plaintiff's interests are entitled to legal protection against the defendant's conduct. ...[Duty] is not sacrosanct in itself, but only an

expression to say that the particular plaintiff is entitled to protection." Also 2nd ed. 1971 at p. 325.

199. See, for example, Hague v. Williams (1962) 181 A. 2d 345.
200. See supra at text accompanying note 87 p. 28.
201. See supra at p. 34 and following.
202. As for example in a case of supervening illegality.
203. Usually if not always a statutory duty.
204. Hague v. Williams (1962) 181 A. 2d 345 at 349: "...when the plaintiffs contracted with defendant for services to be performed for their infant child, he was under a general duty not to disclose frivolously the information received from them, or from an examination of the patient. This is not to say that the patient enjoys an absolute right, but rather that he possesses a limited right against such disclosure, subject to exceptions prompted by the supervening interest of society. We concluded, therefore, that ordinarily a physician receives information relating to a patient's health in a confidential capacity and should not disclose such information without the patient's consent, except where the public interest or the private interest of the patient so demands. Without delineating the precise outer contours of the exceptions, it may generally be said that disclosure may, under such compelling circumstances, be made to a person with a legitimate interest in the patient's health." See also, in a slightly different context, Tournier v. National Provincial and Union Bank of England [1924] 1 K.B. 461 concerning a banker's contractual duty not to disclose the state of his customer's account.
205. See supra p. 34 seq.
206. Report of the Committee on Privacy, London 1972 at p. 297. See also Jones, "Restitution of Benefits Obtained in Breach of Another's Confidence" (1970) 86 L.Q.R. 463 at 472.
207. Per Wood, V.C. in Gartside v. Outram (1856) 26 L.J. Ch. 113 at 114.
208. Weld-Blundell v. Stephens [1919] 1 K.B. 520 at 527, 535; Initial Services Ltd. v. Putterill [1968] 1 Q.B. 396.

209. Fraser v. Evans [1969] 1 Q.B. 349.
210. Ibid. 361 (emphasis added).
211. Ibid. p. 362.
212. Ibid. p. 360.
213. Ibid. p. 362.
214. Ibid.
215. Ibid. pp. 361-62.
216. For an early attempt to categorize the defences to an action in breach of confidence see: Tournier v. National Provincial and Union Bank of England, supra note 204 at 473 where Lord Justice Bankes held the defences to consist of disclosure under compulsion of law, under public duty; where the interest of the defendant so requires, and where the defendant has given his consent.
217. Wade, "Defamation and the Right of Privacy" (1962) 15 Vanderbilt L.R. 1093 at 1112; Warren and Brandeis, in their seminal article on privacy, "The Right to Privacy" (1890) 4 Harvard L.R. 193, were of the opinion that the rules of privilege were applicable to the action for breach of privacy: "The right to privacy does not prohibit the communication of any matter, though in its nature private, when the publication is made under circumstances which would render it a privileged communication according to the law of slander and libel." (at p. 216) Also Prosser, Law of Torts, 4th ed. 1971, p. 817-18.
218. See cases cited by Wade, *ibid.* at pp. 1113-1114.
219. See supra p. 43 seq; Wade, *ibid.* p. 1114.
220. See for example: In Re Abortions in the County of Kings (1954) 135 N.Y.S. 2d 381; 143 N.Y.S. 2d 501; People v. McAlpin (1966) 270 N.Y.S. 2d 899.
221. With regard to the action for breach of statute see supra p. 48 seq. and Linden, Canadian Negligence Law, Chapter 4. With regard to the action in negligence see *infra* and J.C. Smith, "The Mystery of Duty" in Studies in Canadian Tort Law, ed. Klar, Butterworths, Toronto, 1977.

222. For a useful discussion of the many elements of the negligence action see Smith, op. cit. note 23. Wade suggests that the "opportunity to balance conflicting social interests" in the law of negligence is "simpler" and "cleaner" than the similar function of privilege in defamation, and opts for a negligence approach and not a defamation approach for privacy actions. (Wade, "Defamation and the Right of Privacy" op. cit. at p. 1113, 1114-5)
223. (1920) 9 A.L.R. 1250.
224. Ibid. p. 1253.
225. Ibid. For another example of circumstances giving rise to a possible right to disclose see Berry v. Moench 73 A.L.R. 315 at 321, an action sounding in defamation, in which the court refused to disagree with the trial judge's conclusion that there was a privilege to disclose a former patient's psychiatric history to his fiancée. Crockett, J. held: "We do not doubt the correctness of defendant's contention that the responsibility of the doctor to keep confidence may be outweighed by a higher duty to give out information, even though defamatory, if there is a sufficiently important interest to protect... We recognize that such a privilege may also extend to the protection of the interests of third persons under proper circumstances. Where life, safety, well-being or other important interest is in jeopardy, one having information which could protect against the hazard, may have a conditional privilege to reveal information for such purpose, even though it be defamatory and may prove false."
226. Clark v. Geraci (1960) 208 N.Y.S. 2nd 564. The underlying cause was alcoholism. The physician was exonerated on the grounds of duty to disclose and that in the circumstances the client had waived his right to confidence in requesting the incomplete certificates.
227. The extent of the doctor's right of duty to disclose, where he is not himself a party to litigation, is the subject of conflicting decisions, and is effected from state to state by the wording of any privilege statute. See Hague v. Williams (1962) 181 A 2d 345 at 349; Glenn v. Kerlin (1971) 248 S. 2d 834.
228. See Horne v. Patton (1974) 287 S. 2d 824 at 830 (recognizing the existence of a duty to disclose without

defining the circumstances); Doe v. Roe (1977) 400 N.Y.S. 2d 668 at 677. "It is not disputed that under our public policy the right of confidentiality is less than absolute. The evidentiary statute itself...contains its own exceptions. Despite the duty of confidentiality courts have recognized the duty of a psychiatrist to give warning where a patient clearly presents a danger to others...to disclose the existence of a contagious disease,...to report the use of controlled substances in certain situations,...,and to report gunshot and other wounds...I do [not] find it necessary to reach the issue of whether or not an important scientific discovery would take precedence over a patient's privilege of non-disclosure."

229. Tarasoff v. Regents of the University of California (1974) 529 P. 2d 553; Hofmann v. Blackmon (1970) 241 So. 2d 752; Wojcik v. Aluminum Company of America (1959) 183 N.Y.S. 2d 351.
230. Other forms of action, not discussed in detail may be appropriate in a limited number of cases, among these actions in deceit and the action for inducing breach of contract.
231. Several American decisions consider third party liability for inducing breach of confidence. See Panko v. Consolidated Mutual Insurance Company (1970) 423 F. 2d 41 (no proof damage caused by insurance company inducing doctor to breach professional and fiduciary duties); Alexander v. Knight (1962) 177 A. 2d 142 (Court commented that a physician employed by defence attorneys to interview doctors for injured plaintiffs and secure reports on them without consent, and who was not a party to the cause, "is to be and is condemned." (p. 146)); Hammonds v. Aetna Casualty and Surety Company (1965) 243 F. Supp. 793 (an action against an insurance company for inducing breach of confidence by the treating physician on the false pretext patient was contemplating an action against him for professional negligence). See also Halls v. Mitchell [1928] S.C.R. 125, discussed above at page 27-31.

APPENDIX II

Confidentiality Provisions in Ontario Legislation

PART I Provisions regarding Confidentiality of
Information and Penalties for breach
thereof under Legislation administered by
the Ministry of Health

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THE AMBULANCE ACT, R.S.O. 1970, c.20, as am. S.O. 1971, c.50.

Confidential matters - Penalty

18.

(3) Each person employed in the administration of this Act, including any person making an inquiry, inspection or an investigation under this section shall preserve secrecy with respect to all matters that come to his knowledge in the course of his duties, employment, inquiry, inspection or investigation and shall not communicate any such matters to any other person except,

- (a) as may be required in connection with the administration of this Act and the regulations or any proceedings under this Act or the regulations; or
- (b) to his counsel; or
- (c) with the consent of the person to whom the information relates. 1971, c.50, s.5(10).

23.-(1) Subject to subsection 2, any person who contravenes this Act or the regulations is guilty of an offence and on summary conviction is liable to a fine of not more than \$1,000.

(2) Where a corporation is convicted of an offence under subsection 1, the maximum penalty that may be imposed upon the corporation is \$10,000 and not as provided therein.

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THE CANCER ACT, R.S.O. 1970, c.55 as am. S.O. 1972, c.34.

Information confidential

6a.-(1) Any information or report respecting a case of cancer furnished to [The Ontario Cancer Treatment and Research Foundation] by any person shall be kept confidential and shall not be used or disclosed by the Foundation to any person for any reason other than for compiling statistics or carrying out medical or epidemiological research. 1972, c.34, s.1.

.

THE DENTURE THERAPISTS ACT, 1974, S.O. 1974, c.34.

Matters Confidential - Restraining order for non-compliance

22.-(1) Every person employed in the administration of this Act, including any person making an inquiry or investigation under section 21 and any member of the Board or a Committee shall preserve secrecy with respect to all matters that come to his knowledge in the course of his duties, employment, inquiry or investigation under section 21 and shall not communicate any such matters to any other person except,

- (a) as may be required in connection with the administration of this Act and the regulations and by-laws or any proceedings under this Act or the regulations;
- (b) to his counsel; or
- (c) with the consent of the person to whom the information relates.

(2) No person to whom subsection 1 applies shall be required to give testimony in any civil suit or proceeding with regard to information obtained by him in the course of his duties, employment, inquiry or investigation except in a proceeding under this Act or the regulations or by-laws.

25.-(1) Where it appears to the Board that any person does not comply with any provision of this Act or the regulations, notwithstanding the imposition of any penalty in respect of such non-compliance and in addition to any other rights it may have, the Board may apply to a judge of the High Court for an order directing such person to comply with such provision, and upon the application the judge may make such order or such other order as the judge thinks fit.

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continued

THE DENTURE THERAPISTS ACT, 1974 continued

O. Reg. 42/75 - Definition of "professional misconduct"

7. For the purposes of the Act, "professional misconduct" means,

.

10. the contravention of any provisions of the Act or the regulations;

.

26. giving information concerning a patient's dental condition or any service performed for a patient to another person other than the patient without the consent of the patient, unless required to do so by law;

.

THE FUNERAL SERVICES ACT, 1976, S.O. 1976, c.83.

Matters confidential

32.-(1) Every person employed in the administration of this Act, including any person making an inquiry, investigation or inspection under section 31 and any member of the Board or a committee shall preserve secrecy with respect to all matters that come to his knowledge in the course of his duties, employment, inquiry, investigation or inspection under section 31 and shall not communicate any such matters to any other person except,

(a) as may be required in connection with the administration of this Act and the regulations and by-laws or any proceedings under this Act or the regulations;

(b) to his counsel; or

(c) with the consent of the person to whom the information relates.

THE FUNERAL SERVICES ACT, 1976 continued

Testimony in civil suit - Penalties

32.-(2) No person to whom subsection 1 applies shall be required to give testimony in any civil suit or proceeding with regard to information obtained by him in the course of his duties, employment, inquiry, investigation or inspection except in a proceeding under this Act or the regulations or by-laws.

38.

(3) Every person who contravenes any provision of this Act or the regulations for which no penalty is otherwise provided is guilty of an offence and on summary conviction is liable to a fine not exceeding \$2,000.

(4) Where a corporation is convicted of an offence under subsection 1, 2 or 3, the maximum penalty that may be imposed upon the corporation is \$25,000 and not as provided therein.

.

THE HEALTH DISCIPLINES ACT, 1974, S.O. 1974, c.47.

[Note: As substantially similar provisions regarding the powers of discipline committees are contained in Parts II, III, IV, V and VI of this Act, only those provisions relating to Medicine are contained herein (s.60 infra) and may be read as applying, with necessary modifications, to all the other Parts]

PART II - Dentistry

Matters confidential

41.-(1) Every person employed in the administration of this Part, including any person making an inquiry or investigation under section 40 and any member of the Council or a Committee, shall preserve secrecy with respect to all matters that come to his knowledge in the course of his duties, employment, inquiry

or investigation under section 40 and shall not communicate any such matters to any other person except,

- (a) as may be required in connection with the administration of this Part and the regulations and by-laws or any proceedings under this Part or the regulations;
- (b) as may be required for the enforcement of The Health Insurance Act, 1972;
- (c) to his counsel; or
- (d) with the consent of the person to whom the information relates.

(2) No person to whom subsection 1 applies shall be required to give testimony in any civil suit or proceeding with regard to information obtained by him in the course of his duties, employment, inquiry or investigation except in a proceeding under this Part or the regulations or by-laws.

PART III - Medicine

Hearings into allegations of professional misconduct or incompetence - penalties

60.

(5) Where the Discipline Committee finds a member guilty of professional misconduct or incompetence it may by order,

- (a) revoke the licence of the member, or withdraw recognition of his specialist status, or both;
- (b) suspend the licence of the member or recognition of his specialist status, or both, for a stated period;
- (c) impose such restrictions on the licence of the member for such a period and subject to such conditions as the Committee designates;

60.-(5)(d) reprimand the member and, if deemed warranted, direct that the fact of such reprimand be recorded on the register;

(e) impose such fine as the Committee considers appropriate to a maximum of \$5,000 to be paid by the member to the Treasurer of Ontario for payment into the Consolidated Revenue Fund;

(f) direct that the imposition of a penalty be suspended or postponed for such period and upon such terms as the Committee designates,

or any combination thereof.

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Matters confidential

65.-(1) Every person employed in the administration of this Part, including any person making an inquiry or investigation under section 64, and any member of the Council or a Committee, shall preserve secrecy with respect to all matters that come to his knowledge in the course of his duties, employment, inquiry, or investigation under section 64 and shall not communicate any such matters to any other person except,

(a) as may be required in connection with the administration of this Part and the regulations and by-laws or any proceedings under this Part or the regulations; or

(b) as may be required for the enforcement of The Health Insurance Act, 1972;

(c) to his counsel; or

(d) with the consent of the person to whom the information relates.

(2) No person to whom subsection 1 applies shall be required to give testimony in any civil suit or proceeding with regard to information obtained by him in the course of his duties, employment, inquiry or investigation except in a proceeding under this Part or the regulations or by-laws.

[s.64 refers to investigation of members by the Registrar]

PART V - Optometry

Matters confidential

111.-(1) Every person employed in the administration of this Part, including any person making an inquiry or investigation under section 110 and any member of the Council or a Committee shall preserve secrecy with respect to all matters that come to his knowledge in the course of his duties, employment, inquiry or investigation under section 110 and shall not communicate any such matters to any other person except,

- (a) as may be required in connection with the administration of this Part and the regulations and by-laws or any proceedings under this Part or the regulations;
- (b) as may be required for the enforcement of The Health Insurance Act, 1972;
- (c) to his counsel; or
- (d) with the consent of the person to whom the information relates.

(2) No person to whom subsection 1 applies shall be required to give testimony in any civil suit or proceeding with regard to information obtained by him in the course of his duties, employment, inquiry or investigation except in a proceeding under this Part or the regulations or by-laws.

PART VI - Pharmacy

Matters confidential

137.-(1) Every person employed in the administration of this Part, including any person making an inquiry or investigation under section 136, shall preserve secrecy with respect to all matters that come to his knowledge in the course of his duties, employment, inquiry or investigation and shall not communicate any such matters to any other person except,

- 137.-(1)(a) as may be required in connection with the administration of this Part and the regulations and by-laws or any proceedings under this Part or the regulations;
- (b) as may be required for the enforcement of The Health Insurance Act, 1972;
- (c) to his counsel; or
- (d) with the consent of the person to whom the information relates.

(2) No person to whom subsection 1 applies shall be required to give testimony in any civil suit or proceeding with regard to information obtained by him in the course of his duties, employment, inquiry or investigation except in a proceeding under this Part or the regulations or by-laws.

Penalty section

165.

(3) Every person who contravenes any provision of this Act or the regulations for which no penalty is otherwise provided is guilty of an offence and on summary conviction is liable to a fine not exceeding \$2,000. [emphasis added]

Responsibility of pharmacy owner and manager

166.-(1) Every owner or manager of a pharmacy is liable for every offence against this Part committed by any person in his employ or under his supervision with his permission, consent or approval, express or implied, and every director of a corporation operating a pharmacy is liable for every offence against this Part committed by any person in the employ of the corporation with his permission, consent or approval, express or implied.

(2) Where any person operates a pharmacy contrary to this Part or the regulations, the owner and manager of such pharmacy, or either of them, or any director of a corporation operating a pharmacy, may be proceeded against, and prosecution or conviction of either of them is not a bar to prosecution or conviction of the other.

THE HEALTH DISCIPLINES ACT, 1974 continued

O. Reg. 576/75 - Dentistry

Definition of "professional misconduct"

36. For the purpose of Part II of the Act, "professional misconduct" means:

- (1) the contravention of any provision of Part II of the Act or of the regulations or of The Health Insurance Act, 1972;

.

- (29) giving information concerning a patient's dental condition or any professional services performed for a patient to any person other than the patient without the consent of the patient unless required to do so by law;

.

O. Reg. 577/75 - Medicine

Definition of "professional misconduct"

26. For the purpose of Part III of the Act, "professional misconduct" means,

.

2. contravention of any provision of Part III of the Act, The Health Insurance Act, 1972 or the regulations;

.

19. contravening while engaged in the practice of medicine any federal, provincial or municipal law, regulation or rule or a by-law of a hospital designed to protect the public health;

.

21. giving information concerning a patient's condition or any professional services performed for a patient to any person other than the patient without the consent of the patient unless required to do so by law;

.

THE HEALTH DISCIPLINES ACT, 1974 continued

O. Reg. 578/75 - Nursing

Definition of "professional misconduct"

21. For the purposes of Part IV of the Act, "professional misconduct" means,

.

- (k) failure to exercise discretion in respect of the disclosure of confidential information about a patient;

.

O. Reg. 585/75 - Optometry

Definition of "professional misconduct"

26. For the purposes of Part V of the Act, "professional misconduct" means:

.

- 21. Giving information concerning a patient's vision to any person other than the patient without the consent of the patient unless required to do so by law.

.

- 31. The contravention of any provision of Part V of the Act or of the regulations or The Health Insurance Act, 1972.

.

THE HEALTH DISCIPLINES ACT, 1974 continued

O. Reg. 579/75 as am. O. Reg. 647/76 - Pharmacy

Definition of "professional misconduct"

47. For the purposes of Part VI of the Act, "professional misconduct" means:

.

- (q) permitting, consenting to, or approving either expressly or by implication the commission of an offence against any Act relating to the practice of a pharmacist or to the sale of drugs by a corporation of which the member is a director; O. Reg. 647/76, s.5.

.

- (x) conduct or an act relevant to the practice of a pharmacist that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

[Subsection (x) is included as there is no provision in s.47 dealing specifically with the unauthorized release of information]

THE HEALTH INSURANCE ACT, 1972, S.O. 1972, c.91, as am. S.O. 1974, c.60 & c.86.

Matters confidential - General penalty

44.-(1) Each member of the Medical Review Committee, every practitioner review committee, the Medical Eligibility Committee and the Appeal Board and each employee thereof, the General Manager and each person engaged in the administration of this Act and the regulations shall preserve secrecy with respect to all matters that come to his knowledge in the course of his employment or duties pertaining to insured persons and any insured services rendered and the payments made therefor, and shall not communicate any such matters to any other person except as otherwise provided in this Act. 1974, c.60, s.9.

44.-(2) A person referred to in subsection 1 may furnish information pertaining to the date or dates on which insured services were provided and for whom, the name and address of the hospital and health facility or person who provided the services, the amounts paid or payable by the Plan for such services and the hospital, health facility or person to whom the money was paid or is payable, but such information shall be furnished only,

- (a) in connection with the administration of this Act, The Medical Act, The Public Hospitals Act, The Private Hospitals Act, The Ambulance Act or the Hospital Insurance and Diagnostic Services Act (Canada), the Medical Care Act (Canada) or the Criminal Code (Canada), or regulations made thereunder;
- (b) in proceedings under this Act or the regulations;
- (c) to the person who provided the service, his solicitor or personal representative, the executor, administrator or committee of his estate, his trustee in bankruptcy or other legal representative;
- (d) to the person who received the services, his solicitor, personal representative or guardian, the committee or guardian of his estate or other legal representative of that person; or
- (e) pursuant to a subpoena by a court of competent jurisdiction. 1974, c.86, s.2.

44.-(3) The information referred to in subsection 1 may be published by the Ministry of Health in statistical form if the individual names and identities of persons who received insured services are not thereby revealed.

(4) The General Manager may communicate information of the kind referred to in subsection 2 and any other information pertaining to the nature of the insured services provided and any diagnosis given by the person who provided the services to the statutory body governing the profession or to a professional association of which he is a member.

50. Every person who contravenes any provision of this Act or the regulations for which no penalty is specifically provided is guilty of an offence and on summary conviction is liable to a fine of not more than \$2,000.

[Note: s.3 of this Act states that "where the provisions of any Act conflict with the provisions of this Act or the regulations, the provisions of this Act and the regulations prevail."]

Clinical record - interpretation - disclosure

[s.26a. applies to all psychiatric facilities designated as such in Regulation 576 made under this Act]

26a.-(1) In this section,

- (a) "clinical record" means the clinical record compiled in a psychiatric facility in respect of a patient, and includes a part of a clinical record;
- (b) "patient" includes former patient, out-patient, and former out-patient.

(2) Except as provided in subsections 3 and 5, no person shall disclose, transmit or examine a clinical record.

(3) The officer in charge and the attending physician in the psychiatric facility in which a clinical record was prepared may examine the clinical record and the officer in charge may disclose or transmit the clinical record to or permit the examination of the clinical record by,

- (a) where the patient has attained the age of majority and is mentally competent, any person with the consent of the patient;
- (b) where the patient has not attained the age of majority or is not mentally competent, any person with the consent of the nearest relative of the patient;
- (c) any person employed in or on the staff of the psychiatric facility for the purpose of assessing or treating or assisting in assessing or treating the patient;

Clinical record - disclosure - research/statistics - subpoena

26a.-(3)(d) the chief executive officer of a health facility that is currently involved in the direct health care of the patient upon the written request of the chief executive officer to the officer in charge;

(e) with the consent of the patient or, where the patient has not attained the age of majority or is not mentally competent, with the consent of the nearest relative of the patient or, where delay in obtaining the consent of either of them would endanger the life, a limb or a vital organ of the patient, without the consent of either of them, a person currently involved in the direct health care of the patient in a health facility;

(f) a person for the purpose of research, academic pursuits or the compilation of statistical data.

(4) Where a clinical record,

(a) is transmitted or copied for use outside the psychiatric facility for the purpose of research, academic pursuits or the compilation of statistical data, the officer in charge shall remove from the part of the clinical record that is transmitted or from the copy, as the case may be, the name of and any means of identifying the patient; and

(b) is disclosed to or examined by a person for the purpose of research, academic pursuits or the compilation of statistical data, the person shall not disclose the name of or any means of identifying the patient and shall not use or communicate the information or material in the clinical record for a purpose other than research, academic pursuits or the compilation of statistical data.

(5) Subject to subsections 6 and 7, the officer in charge or a person designated in writing by the officer in charge shall disclose, transmit or permit the examination of a clinical record pursuant to a subpoena, order, direction, notice or similar requirement in respect of a matter in issue or that may be in issue in a court of competent jurisdiction or under any Act.

THE MENTAL HEALTH ACT continued

Clinical record - disclosure - statement by attending physician
- matters to be considered by court or body

26a.-(6) Where the disclosure, transmittal or examination of a clinical record is required by a subpoena, order, direction, notice or similar requirement in respect of a matter in issue or that may be in issue in a court of competent jurisdiction or under any Act and the attending physician states in writing that he is of the opinion that the disclosure, transmittal or examination of the clinical record or of a specified part of the clinical record,

(a) is likely to result in harm to the treatment or recovery of the patient; or

(b) is likely to result in,

(i) injury to the mental condition of a third person, or

(ii) bodily harm to a third person,

no person shall comply with the requirement with respect to the clinical record or the part of the clinical record specified by the attending physician except under an order of,

(c) the court before which the matter is or may be in issue; or

(d) where the disclosure, transmittal or examination is not required by a court, under an order of the Divisional Court,

made after a hearing from which the public is excluded and that is held on notice to the attending physician.

(7) On hearing under subsection 6, the court or body shall consider whether or not the disclosure, transmittal or examination of the clinical record or the part of the clinical record specified by the attending physician

(a) is likely to result in harm to the treatment or recovery of the patient; or

(b) is likely to result in,

Clinical record - matters to be considered by court or body -
return of record - disclosure in action or proceeding

26a.-(7)(b) (i) injury to the mental condition of a third person, or

(ii) bodily harm to a third person,

and for the purpose the court or body may examine the clinical record, and, if satisfied that such a result is likely, the court or body shall not order the disclosure, transmittal or examination unless satisfied that to do so is essential in the interests of justice.

(8) Where a clinical record is required pursuant to subsection 5 or 6, the clerk of the court or body in which the clinical record is admitted in evidence or, if not so admitted, the person to whom the clinical record is transmitted shall return the clinical record to the officer in charge forthwith after the determination of the matter in issue in respect of which the clinical record was required.

(9) No person shall disclose in an action or proceeding in any court or before any body any knowledge or information in respect of a patient obtained in the course of assessing or treating or assisting in assessing or treating the patient in a psychiatric facility or in the course of his employment in the psychiatric facility except,

- (a) where the patient has attained the age of majority and is mentally competent, with the consent of the patient;
- (b) where the patient has not attained the age of majority or is not mentally competent, with the consent of the nearest relative of the patient; or
- (c) where the court or, in the case of a proceeding not before a court, the Divisional Court determines, after a hearing from which the public is excluded and that is held on notice to the patient or (where the patient has not attained the age of majority or is not mentally competent) the nearest relative of the patient, that the disclosure is essential in the interests of justice. 1978, c.50, s.10.

THE MENTAL HEALTH ACT continued

PART V - Miscellaneous

Offence

60. Every person who contravenes any provision of this Act or the regulations is guilty of an offence and on summary conviction is liable to a fine of not more than \$10,000. 1978, c.50, s.19.

THE NURSING HOMES ACT, 1972, S.O. 1972, c.11.

Records - possession/control

12.

(3) Where the licensee's licence is revoked, the licensee and the administrator shall hand over to the Minister, or a person designated by him, all the records that are in their possession or control and that pertain to the residents of the nursing home.

Penalty

18. Any person who contravenes any provision of this Act or the regulations, except subsection 1 of section 12, is guilty of an offence and on summary conviction is liable to a fine of not more than \$2,000.

[s.12(1) refers to removal of residents]

continued

O. Reg. 196/72.

Records - non-removal - access

90. Except as otherwise provided in this Regulation,

- (a) the personal file of a resident; or
- (b) the personnel records of the nursing home,

shall not be removed from a nursing home by any person other than an inspector.

91.-(1) Subject to subsections 2, 3 and 4, no person other than an inspector shall have access to the medical or drug record of a resident.

(2) Subsection 1 does not apply to,

- (a) a person with a process,
 - (i) issued in Ontario out of a court of record or any other court, and
 - (ii) ordering the removing of, the inspecting of or the receiving of information from a medical record; or
- (b) an inspector.

(3) Notwithstanding subsection 1, a coroner or a legally qualified medical practitioner, magistrate or police officer so authorized and directed by a coroner, may inspect and receive information from medical or drug records and may reproduce and and retain copies therefrom for the purposes of an inquest or to determine whether an inquest is necessary where the coroner has,

- (a) issued his warrant to take possession of the body;
- (b) issued his warrant for an inquest; or
- (c) attended at the nursing home to view the body and make an investigation in accordance with The Coroners Act;

THE NURSING HOMES ACT, 1972 continued

O. Reg. 196/72 (cont'd)

Records - access - patient consent

91.-(4) Notwithstanding subsection 1,

- (a) the resident's attending physician or dentist;
- (b) a member of the nursing staff;
- (c) the administrator of another nursing home to which the resident has been transferred;
- (d) a person who presents a written request signed by,
 - (i) the resident,
 - (ii) where the record is of a former resident now deceased, his personal representative, or
 - (iii) the parent or guardian of an unmarried resident under eighteen years of age,

may be permitted to inspect and receive information from the resident's medical or drug record and be given copies therefrom.

.

THE PRIVATE SANITARIA ACT, R.S.O. 1970, c.363.

Board of visitors

3.-(1) Every sanitarium shall be under the supervision and inspection of a board of visitors composed of the judge or, in the case of his absence or disqualification, a junior judge of the county or district court, the clerk of the peace and the sheriff of the county or district in which the sanitarium is situate, together with two medical practitioners appointed by the Lieutenant Governor in Council who shall hold office for three years unless sooner removed by him.

.

THE PRIVATE SANITARIA ACT continued

Oath of board of visitors - oath of assistant secretary

3.-(6) Every member of the board shall, before acting, take and subscribe the following oath:

"I, A.B., do swear that I will discreetly, impartially and faithfully execute all the trusts and powers committed to me by virtue of The Private Sanitaria Act, and that I will keep secret all such matters as come to my knowledge in the execution of my office, except when required to divulge the same by legal authority, or so far as I feel myself called upon to do so for the better execution of the duty imposed upon me by the said Act. So help me God."

(7) The oath shall be filed in the office of the clerk of the peace.

.

(10) If the secretary at any time desires to employ an assistant in the execution of his duties, he shall certify such desire and the name of the proposed assistant to the chairman of the board, and, if such assistant is approved of, the chairman shall administer the following oath to such assistant:

"I, A.B., do swear that I will faithfully keep secret all such matters and things as come to my knowledge in consequence of my employment as assistant to the secretary of the Board of Visitors, appointed for the county or district ofby virtue of The Private Sanitaria Act, unless required to divulge the same by legal authority. So help me God."

THE PUBLIC HOSPITALS ACT, R.S.O. 1970, c.378.

Medical records

11. The medical record compiled in a hospital for a patient or an out-patient is the property of the hospital and shall be kept in the custody of the administrator.

Offence

36. Every person who contravenes or is a party to the contravention, directly or indirectly, of any provision of this Act or the regulations is guilty of an offence and on summary conviction is liable to a fine of not less than \$25 and not more than \$500.

R.R.O. 1970, Regulation 729 as am. O. Reg. 193/72 &
O. Reg. 100/74.

Medical Record - non-disclosure - access - Coroner

48.-(1) Subject to subsections 2, 3, 4 and 5, a board shall not permit any person to remove, inspect or receive information from a medical record.

(2) Subsection 1 does not apply to,

(a) a person with a process,

(i) issued in Ontario out of a court of record or any other court, and

(ii) ordering the removing of, the inspecting of or the receiving of information from a medical record; or

(b) an inspector.

(3) Notwithstanding subsection 1, a coroner or a legally qualified medical practitioner, magistrate or police officer so authorized in writing and directed by a coroner, may inspect and receive information from medical records and may reproduce and retain copies therefrom for the purposes of an inquest or to determine whether an inquest is necessary, where the coroner has,

(a) issued his warrant to take possession of the body;

(b) issued his warrant for an inquest; or

R.R.O. 1970, Regulation 729 (cont'd)

Medical Record - access - The College of Physicians and Surgeons

48.-(3)(c) attended at the hospital to view the body and make an investigation in accordance with The Coroners Act.

(4) Notwithstanding subsection 1,

(a) the registrar and the elected members of the Council of The College of Physicians and Surgeons of Ontario, ex officio; and

(b) a medical practitioner or medical practitioners appointed by The College of Physicians and Surgeons of Ontario,

after giving notice to the administrator may, for the purposes of the College,

(c) inspect and receive information from medical records and may reproduce and retain copies therefrom; and

(d) require all members of the medical staff and hospital employees to answer inquiries concerning the admission, treatment, care, conduct, control and discharge of patients or any class of patients and the general management of the hospital insofar as that relates to the hospitalization of the particular patient or patients whose care and treatment are being investigated by the College.

(4a) The registrar of The College of Physicians and Surgeons of Ontario shall make a full and complete report in writing to the Minister forthwith after receiving any report made to the College under subsection 4. O. Reg. 193/72, s.1.

THE PUBLIC HOSPITALS ACT continued

R.R.O. 1970, Regulation 729 (cont'd)

Medical Record - access - hospital personnel- patient consent -
Veterans Affairs (Canada) - Ministry of Health

48.-(5) A board may permit,

- (a) the attending physician;
- (b) the administrator of another hospital who makes a written request to the administrator;
- (c) a person who presents a written request signed by,
 - (i) the patient,
 - (ii) where the record is of a former patient, deceased, his personal representative; or
 - (iii) the parent or guardian of an unmarried patient under eighteen years of age;
- (d) a member of the medical staff but only for,
 - (i) teaching purposes, or
 - (ii) scientific research that has been approved by the medical-staff advisory committee;
- (e) a person with a written direction from the Deputy Minister of Veterans Affairs (Canada) or some person designated by him, where the patient is a member or ex-member of Her Majesty's military, naval or air force of Canada; or
- (f) the Director of the Research and Planning Branch or the Department or his authorized representative approved by the Commission or an officer or employee of the Commission who is designated by the Chairman,

to inspect and receive information from a medical record and to be given copies therefrom.

THE PUBLIC HOSPITALS ACT continued

R.R.O. 1970, Regulation 729 (cont'd)

Medical Record - disclosure

48.-(6) Any information received under clause f of subsection 5 shall not be used or disclosed to any person for any purpose other than the purposes of compiling statistics and carrying out medical and epidemiological research for or approved by the Department and the Commission.

(7) Notwithstanding sections 39, 42, 43, 44 and 48, a hospital, with the prior approval of the Minister, may participate in and provide medical record information to a haematology users group computer system for the centralized recording and maintaining of haematological medical record information relating to any patient, his disease and the results of his blood grouping, transfusions, antibody determinations, blood morphological interpretations and any other blood and serum tests, so that such information will be stored in such a manner that it will be quickly accessible, on demand and without the consent of the patient, to the laboratory personnel and to the attending physician in any other hospital. O. Reg. 100/74, s.10, part.

(8) Notwithstanding sections 39, 42, 43, 44 and 48, a hospital, when requested to do so by the Minister, shall provide medical record information and X-ray films to the Tuberculosis Prevention Service of the Ministry and to The Ontario Cancer Treatment and Research Foundation. O. Reg. 100/74, s.10, part.

THE VENEREAL DISEASES PREVENTION ACT, R.S.O. 1970, c.479.

Offence and Penalty

12.-(1) Every person who,

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(c) publishes any proceedings taken under this Act or the regulations contrary to subsection 2;

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12.-(1)(f) fails to comply with any of the provisions of this Act or the regulations,

is guilty of an offence and, where no other penalty is prescribed, is liable to a fine of not less than \$25 and not more than \$100 and in default of immediate payment shall be imprisoned for a term of not more than three months.

(2) The Summary Convictions Act applies to prosecutions under this Act or the regulations but all proceedings for the recovery of penalties under this Act and proceedings authorized by section 6 shall be conducted in camera and no person shall publish or disclose any such proceedings except under the authority of this Act or the regulations.

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Statements re existence of disease - Exceptions

13.-(1) Every person who publicly or privately, verbally or in writing, directly or indirectly, states or intimates that any other person has been notified or examined or otherwise dealt with under this Act, whether such statement or intimation is or is not true, is guilty of an offence, and in addition to any other penalty or liability, is liable to a fine of \$200 and in default of immediate payment shall be imprisoned for a term of not more than six months.

(2) Subsection 1 does not apply,

(a) to a communication or disclosure made in good faith,

(i) to the Minister or Deputy Minister of Health,

(ii) to a medical officer of health for his information in carrying out the provisions of this Act,

(iii) to a physician,

(iv) in the course of consultation for treatment for venereal disease,

THE VENEREAL DISEASES PREVENTION ACT continued

Statements re existence of disease - Exceptions (cont'd)

13.-(2)(a) (v) to the superintendent or head of any place of detention;

(b) to any evidence given in any judicial proceedings of facts relevant to the issue; or

(c) to any communication authorized or required to be made by this Act or the regulations.

(3) Notwithstanding subsection 1, a physician may give information concerning the patient to other members of the patient's family for the protection of health.

Obligation to observe secrecy

14. Every person engaged in the administration of this Act shall preserve secrecy with regard to all matters that may come to his knowledge in the course of such employment and shall not communicate any such matter to any other person except in the performance of his duties under this Act or when instructed to do so by a medical officer of health or the Minister and in default he shall in addition to any other penalty forfeit his office or be dismissed from his employment.

Laboratory reports

15. No person shall issue or make available to any person other than a physician or such persons as are engaged in the administration of this Act any laboratory report either in whole or in part of an examination made to determine the presence or absence of venereal disease.

Payment of expenses by municipalities - offence

18.

(2) The name of any person infected or suspected to be infected with any venereal disease shall not appear on any account in connection with treatment therefor, but the case shall be designated by a number and it is the duty of every local board of health to see that secrecy is preserved.

(3) Every person who contravenes the provisions of subsection 2 is guilty of an offence and is liable to the penalties provided by sections 13 and 14.

Where person infected is under 16 years of age

21. Where any person infected or believed to be infected with venereal disease is a child under the age of sixteen years, all notices, directions or orders required or authorized by this Act or by the regulations to be given in respect of the child shall be given to the father or mother or to the person having the custody of the child for the time being and it is the duty of the father, mother or other person to see that the child complies in every respect with every such notice, order or direction and in default thereof the father, mother or other person, as the case may be, is liable to the penalties provided by this Act or the regulations for non-compliance with any such notice, direction or order unless on any prosecution in that behalf it is proven to the satisfaction of the court that the father, mother or other person did everything in his power to cause the child to comply therewith.

PART II Provisions regarding Confidentiality of
Information and Penalties for breach
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THE AUDIT ACT, 1977, S.O. 1977, c.61.
[administered by the Provincial Auditor]

Oath of office and secrecy - cause for dismissal - information
confidential

21.-(1) Every employee of the Office of the Auditor, before performing any duty as an employee of the Auditor, shall take and subscribe before the Auditor or a person designated in writing by the Auditor,

(a) the following oath of office and secrecy:

I,....., do swear (or solemnly affirm) that I will faithfully discharge my duties as an employee of the Provincial Auditor and will observe and comply with the laws of Canada and Ontario and, except as I may be legally required, I will not disclose or give to any person any information or document that comes to my knowledge or possession by reason of my being an employee of the Office of the Auditor.

So help me God. (Omit this line in an affirmation).

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(2) The Auditor may require any person or class of persons appointed to assist the Auditor for a limited period of time or in respect of a particular matter to take and subscribe either or both of the oaths set out in subsection 1.

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(4) The failure of an employee of the Office of the Auditor to take and subscribe or to adhere to either of the oaths required by subsection 1 may be considered as cause for dismissal.

27.

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(2) The Auditor, the Assistant Auditor and each person employed in the Office of the Auditor or appointed to assist the Auditor for a limited period of time or in respect of a particular matter shall preserve secrecy with respect to all matters that come to his knowledge in the course of his employment or duties under this Act and shall not communicate any such matters to any person, except as may be required in connection with the administration of this Act or any proceedings under this Act or under the Criminal Code (Canada).

Part II - Protection and Care of Children

Information concerning abuse - Register - information
confidential - exceptions

52.

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(3) The Director [appointed by the Minister of Community and Social Services for the purposes of s.52] shall maintain a register in the manner prescribed by the regulations for the purpose of recording information received by societies under section 49 concerning the abuse of children, but the register shall not contain any information that has the effect of identifying the person or persons making the report to a society pursuant to subsection 1 or 2 of section 49 unless such person or persons are themselves the subject of the report.

(4) Subject to subsections 5 to 10 and notwithstanding the provisions of any other Act, no person shall inspect, remove, disclose, transmit or alter or permit the inspection, removal, disclosure, transmission or alteration of information maintained in the register established under subsection 3.

(5) A coroner, a legally qualified medical practitioner or police officer authorized in writing and directed by a coroner for the purposes of an investigation or inquest under The Coroners Act, 1972 and the Official Guardian or a person duly authorized as the agent of the Official Guardian may inspect or remove the information maintained in the register established under subsection 3 and may disclose or transmit that information only in accordance with the authority vested in the person and in the case of the Official Guardian or his duly authorized agent only for the purposes of section 51. [action for recovery on behalf of a child re abuse]

(6) The Director and the following persons with the approval of the Director, and subject to such terms and conditions as the Director may impose, may inspect or remove or permit the inspection or removal of the information maintained in the register and may disclose or transmit or permit the disclosure or transmission of that information to any person referred to in subsection 5 or to any other person referred to in this subsection:

THE CHILD WELFARE ACT, 1978 continued

Information confidential - exceptions - Register inadmissible

- 52.-(6)1. A person who is on the staff of,
- i. the Ministry,
 - ii. a society, or
 - iii. a child protection agency recognized by a jurisdiction outside Ontario.
2. A person who is or may be providing services or treatment to a registered person.

(7) A person who has the written approval of the Director and who is engaged in bona fide research may inspect the information referred to in subsection 4 but shall not use or communicate the information for a purpose other than research, academic pursuits or the compilation of statistical data and shall not communicate any information that has the effect of identifying any person named in the register.

(8) A registered person or the registered person's agent may inspect the information maintained in the register, but shall not inspect information that refers to persons other than the registered person.

(9) A legally qualified medical practitioner who is approved by the Director may inspect information referred to in subsection 4 that is approved by the Director.

(10) The Director or a person approved by the Director who is on the staff of the Ministry may expunge a name from the register or otherwise amend the register pursuant to a decision of the Director or as prescribed by the regulations.

(11) The register established under subsection 3 is inadmissible in evidence for any purpose in any proceedings, except,

- (a) to prove compliance or non-compliance with any of the provisions of this section;
- (b) in an appeal made under subsection 19;
- (c) in proceedings under The Coroners Act, 1972; or
- (d) in proceedings referred to in section 51.

[ss.12 to 20 deal with notices, hearings and appeals re expunging from register names of persons alleged or suspected to have abused a child]

Record of proceedings at hearing inadmissible

52.-(21) The record of proceedings in any hearing held under subsection 14 or in any appeal under subsections 19 and 20 is inadmissible in evidence in any other proceeding for any purpose except proceedings under clause c and subclause iv of clause f of subsection 1 of section 94.

[ss.94(1)(c) & (f)(iv) are the Offence sections relating to breach of s.52(17) re amending the child abuse register and ss.52(4), (7) & (8) re access to the register]

PART III - Adoption

Voluntary disclosure registry - information confidential

81.

(4) Notwithstanding the provisions of any other Act, no person shall inspect, remove, disclose, transmit or alter or permit the inspection, removal, disclosure, transmission or alteration of information maintained in the voluntary disclosure registry established under subsection 2, except with the written permission of the Director.

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PART IV - General - Offence

94.-(1) Every person who,
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(f) contravenes any provision of,

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(iv) subsection 4, 7 or 8 of section 52,

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and every director, officer or employee of a corporation who knowingly concurs in such contravention by the corporation or in such furnishing of false information, failure, hindrance, obstruction or interference or attempted hindrance, obstruction or interference or contravention by the corporation is guilty of an offence and on summary conviction by the court is liable to a fine of not more than \$1,000 or, except for a contravention of subsection 2 of section 49, to imprisonment for a term of not more than one year, or to both.

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THE CONSUMER REPORTING ACT, 1973, S.O. 1973, c.97.

[administered by the Ministry of Consumer and Commercial Relations]

[Note: "consumer" is defined as "a natural person but does not include a person engaging in a transaction, other than relating to employment, in the course of carrying on a business, trade or profession"; "information" includes "personal information" which is defined as "information other than credit information about a consumer's character, reputation, health, physical or personal characteristics or mode of living or about any other matter concerning the consumer"]

To whom reports may be given

8.-(1) No consumer reporting agency and no officer or employee thereof shall knowingly furnish any information from the files of the consumer reporting agency except,

- (a) in response to the order of a court having jurisdiction to issue such an order;
- (b) in accordance with the written instructions of the consumer to whom the information relates;
- (c) in response to an order or direction made under this Act; or
- (d) in a consumer report given to a person who it has reason to believe,

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- (iv) intends to use the information in connection with the underwriting of insurance involving the consumer,

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- (vi) otherwise has a direct business need for the information in connection with a business or credit transaction involving the consumer, or

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(2) No person shall knowingly obtain any information from the files of a consumer reporting agency respecting a consumer except for the purposes referred to in subsection 1.

Information as to identities - sale of files

8.-(3) Notwithstanding subsections 1 and 2, a consumer reporting agency may furnish identifying information respecting any consumer, limited to his name, address, former addresses, places of employment, or former places of employment, to the Government of Ontario or of Canada or any province thereof or of any agency of such government or the government of any municipality in Canada or any agency thereof or to any police officer acting in the course of his duties, notwithstanding that such information is not to be used for a purpose mentioned in subsection 1.

(4) No person who is or has been registered as a consumer reporting agency shall sell, lease or transfer title to its files or any of them except to a consumer reporting agency registered under this Act.

[Sections 9 to 17 deal with the accuracy of reports, with information that shall not be included (health information is not excluded except as noted below), notices and disclosure to consumers, corrections to reports, appeals to the Registrar re these matters, and investigation of complaints by the Registrar or the Minister or the Director of the Business Practices Division; note that certain medical information is specifically excluded from disclosure to the consumer: "a consumer reporting agency shall withhold...any medical information obtained with the written consent of the consumer which the consumer's own physician has specifically requested in writing be withheld from the consumer in his own best interest" (s.11(2)).]

Matters confidential - testimony in civil suit

18.-(1) Every person employed in the administration of this Act, including any person making an inquiry, inspection or an investigation under section 15, 16 or 17 shall preserve secrecy in respect of all matters that come to his knowledge in the course of his duties, employment, inquiry, inspection or investigation and shall not communicate any such matters to any other person except,

Matters confidential - testimony in civil suit

18.-(1) cont'd

- (a) as may be required in connection with the administration of this Act and the regulations or any proceedings under this Act or the regulations; or
- (b) to his counsel; or
- (c) with the consent of the person to whom the information relates.

(2) No person to whom subsection 1 applies shall be required to give testimony in any civil suit or proceeding with regard to information obtained by him in the course of his duties, employment, inquiry, inspection or investigation except in a proceeding under this Act or the regulations.

Offences

22.-(1) Every person who,

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- (b) fails to comply with any order, direction or other requirement made under this Act; or
- (c) contravenes any provision of this Act or the regulations,

and every director or officer of a corporation who knowingly concurs in such furnishing, failure or contravention is guilty of an offence and on summary conviction is liable to a fine of not more than \$2,000 or to imprisonment for a term of not more than one year, or to both.

(2) Where a corporation is convicted of an offence under subsection 1, the maximum penalty that may be imposed upon the corporation is \$25,000 and not as provided therein.

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PART IX - Teachers

Pupil records - privilege - right of parent and pupil

231.-(1) In this section, except in subsection 12, "record" in respect of a pupil means a record maintained or retained by the principal of a school in accordance with the regulations.

(2) A record is privileged for the information and use of supervisory officers and the principal and teachers of the school for the improvement of instruction of the pupil, and such record,

- (a) subject to subsections 3 and 5, is not available to any other person; and
- (b) except for the purposes of subsection 5, is not admissible in evidence for any purpose in any trial, inquest, inquiry, examination, hearing or other proceeding, except to prove the establishment, maintenance, retention or transfer of the record,

without the written permission of the parent or guardian of the pupil or, where the pupil is an adult, the written permission of the pupil.

(3) A pupil, and his parent or guardian where the pupil is a minor, is entitled to examine the record of such pupil.

(4) Where, in the opinion of a pupil who is an adult, or of the parent or guardian of a pupil who is a minor, information recorded upon the record of the pupil is,

- (a) inaccurately recorded; or
- (b) not conducive to the improvement of instruction of the pupil,

such pupil, parent or guardian, as the case may be, may, in writing, request the principal to correct the alleged inaccuracy in, or to remove the impugned information from, such record.

[ss.(5) deals with referral to supervisory officers upon disagreements between pupil (or representative) and principal re amending record]

Pupil records - use for further education/employment, Minister or board - testimony and secrecy re content

231.-(6) Nothing in subsection 2 prohibits the use by the principal of the record in respect of a pupil to assist in the preparation of,

- (a) a report required by this Act or the regulations; or
- (b) a report,
 - (i) for an educational institution or for the pupil or former pupil, in respect of an application for further education, or
 - (ii) for the pupil or former pupil in respect of an application for employment,

where a written request is made by the former pupil, the pupil where he is an adult, or the parent or guardian of the pupil where the pupil is a minor.

(7) Nothing in this section prevents the compilation and delivery of such information as may be required by the Minister or by the board.

(8) No action shall be brought against any person in respect of the content of a record.

(9) Except where the record has been introduced in evidence as provided in this section, no person shall be required in any trial or other proceeding to give evidence in respect of the content of a record.

(10) Except as permitted under this section, every person shall preserve secrecy in respect of the content of a record that comes to his knowledge in the course of his duties or employment, and no such person shall communicate any such knowledge to any other person except,

- (a) as may be required in the performance of his duties; or
- (b) with the written consent of the parent or guardian of the pupil where the pupil is a minor; or
- (c) with the written consent of the pupil where the pupil is an adult.

(11) For the purposes of this section, "guardian" includes a person, society or corporation who or that has custody of a pupil.

THE EDUCATION ACT, 1974 continued

Pupil records - application to former records - use in disciplinary cases

231.-(12) This section, except subsections 3, 4 and 5, applies mutatis mutandis to a record established and maintained in respect of a pupil or retained in respect of a former pupil prior to the 1st day of September, 1972.

(13) Nothing in this section prevents the use of a record in respect of a pupil by the principal of the school attended by the pupil or the board that operates the school for the purposes of a disciplinary proceeding instituted by the principal in respect of conduct for which the pupil is responsible to the principal.

THE ENERGY ACT, 1971, S.O. 1971, Vol.2, c.44.

[administered by the Ministry of Consumer and Commercial Relations]

Confidentiality - compellability in a civil suit

6.-(1) An inspector shall not publish, disclose or communicate to any person any information, record, report or statement acquired, furnished, obtained, made or received under the powers conferred under this Act and the regulations except for the purposes of carrying out his duties under this Act and the regulations.

(2) An inspector is not a compellable witness in a civil suit or proceeding respecting any information, record, report, statement or test acquired, furnished, obtained, made or received under the powers conferred under this Act and the regulations.

continued

THE ENERGY ACT, 1971 continued

Confidentiality - exception - Offence

6.-(3) The Director may disclose or publish information, material, statements or result of a test acquired, furnished, obtained or made under the powers conferred under this Act and the regulations.

27. Every person who,

(a) contravenes or fails to comply with any provision of this Act or the regulations;

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is guilty of an offence and on summary conviction is liable to a fine of not more than \$10,000 or to imprisonment for a term of not more than one year, or to both.

THE GENERAL WELFARE ASSISTANCE ACT, R.S.O. 1970, c.192.
[administered by the Ministry of Community and Social Services]

R.R.O. 1970, Regulation 383.

Publication

9. No municipality or approved band shall print for public distribution, broadcast or post up in a public place, or cause to be so printed, broadcast or posted up or otherwise cause to be made public, the identity of any person who is eligible for or receives assistance.

THE HIGHWAY TRAFFIC ACT, R.S.O. 1970, c.202, as am. S.O. 1977, c.54.

[administered by the Ministry of Transportation and Communications]

PART III - Licence, (Driver, Driving Instructor)

Documents privileged

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(7) Documents filed with the Ministry relating to mental and physical, including ophthalmic and auditory, examinations pursuant to this section are privileged for the information of the Ministry only and shall not be open for public inspection. 1977, c.54, s.1.

PART XIII - Records and Reporting of Accidents and Convictions

Report of Medical Practitioner - no action for compliance -
Reports privileged

143.-(1) Every legally qualified medical practitioner shall report to the Registrar the name, address and clinical condition of every person sixteen years of age or over attending upon the medical practitioner for medical services, who in the opinion of such medical practitioner is suffering from a condition that may make it dangerous for such person to operate a motor vehicle.

(2) No action shall be brought against a qualified medical practitioner for complying with this section.

(3) The report referred to in subsection 1 is privileged for the information of the Registrar only and shall not be open for public inspection, and such report is inadmissible in evidence for any purpose in any trial except to prove compliance with subsection 1.

THE HIGHWAY TRAFFIC ACT continued

Report of Optometrist - no action for compliance - Reports privileged

144.-(1) Every optometrist registered under The Optometry Act shall report to the Registrar the name, address and clinical condition of every person sixteen years of age and over attending upon the optometrist for optometric services who, in the opinion of such optometrist, is suffering from an eye condition that may make it dangerous for such person to operate a motor vehicle.

(2) No action shall be brought against a qualified optometrist for complying with this section.

(3) The report referred to in subsection 1 is privileged for the information of the Registrar only and shall not be open for public inspection, and such report is inadmissible in evidence for any purpose in any trial except to prove compliance with subsection 1.

PART XIV - Procedures, Arrests and Penalties

General penalty

152. Every person who contravenes any of the provisions of this Act or of any regulation is guilty of an offence and on summary conviction, where a penalty for the contravention is not otherwise provided for herein, is liable to a fine of not less than \$20 and not more than \$100.

THE HOMES FOR THE AGED AND REST HOMES ACT, R.S.O. 1970, c.206.
[administered by the Ministry of Community and Social Services]

R.R.O. 1970, Regulation 439 as am. O. Reg. 677/78.

Powers and Duties of Administrators

5. An administrator,

(a) is responsible to the council of the municipality that establishes and maintains the home, the councils of the municipalities that establish and maintain a joint home or to the board, as the case may be, for,

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(iv) maintaining the confidentiality of all records and protecting the privacy and rights of the residents;
O. Reg. 677/78, s.1(1).

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Record of Residents

17.-(1) A home shall keep a written record or series of records of each resident that shall be maintained in confidence.

(2) The record shall include,

(a) a detailed report of the social and medical history of a resident before admission and all physical and mental examinations and all illnesses and accidents after admission; O. Reg. 677/78, s.4, part.

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No Offence section.

THE HUMAN TISSUE GIFT ACT, 1971, S.O. 1971, Vol.2, c.83.
[administered by the Ministry of the Solicitor General]

Disclosure of information - Offence

11.-(1) Except where legally required, no person shall disclose or give to any other person any information or document whereby the identity of any person,

- (a) who has given or refused to give a consent;
- (b) with respect to whom a consent has been given; or
- (c) into whose body tissue has been, is being or may be transplanted,
may become known publicly.

(2) Where the information or document disclosed or given pertains only to the person who disclosed or gave the information or document, subsection 1 does not apply.

13. Every person who knowingly contravenes any provision of this Act is guilty of an offence and on summary conviction is liable to a fine of not more than \$1,000 or to imprisonment for a term of not more than six months, or to both.

THE INCOME TAX ACT, R.S.O. 1970, c.217.
[administered by the Ministry of Revenue]

Offence, secrecy

44.-(1) Every person who, while employed in the administration of this Act, has communicated or allowed to be communicated to a person not legally entitled thereto any information obtained under this Act or has allowed any such person to inspect or have access to any written statement furnished under this Act is guilty of an offence and on summary conviction is liable to a fine of not more than \$200.

(2) Subsection 1 does not apply to the communication of information between,

- (a) the Minister [of National Revenue for Canada] and the Provincial Minister [of Revenue for Ontario]; or
- (b) the Minister, acting on behalf of Ontario, and the Provincial Minister, the Provincial Secretary-Treasurer, or the Minister of Finance of the government of,
 - (i) an agreeing province, or
 - (ii) a non-agreeing province to which an adjusting payment may be made under subsection 2 of section 52.

THE LIQUOR LICENCE ACT, 1975, S.O. 1975, c.40, as am. S.O. 1978, c.42.

[administered by the Ministry of Consumer and Commercial Relations]

Confidentiality - testimony in civil suit

25.-(1) Every person employed in the administration of this Act, including any person making an inquiry, inspection or an investigation under this Act, shall preserve secrecy in respect of all matters that come to his knowledge in the course of his duties, employment, inquiry, inspection or investigation and shall not communicate any such matters to any other person except,

- (a) as may be required in connection with the administration of this Act and the regulations or any proceedings under this Act; or
- (b) to his counsel; or
- (c) with the consent of the person to whom the information relates.

(2) No person to whom subsection 1 applies shall be required to give testimony in any civil suit or proceeding with regard to information obtained by him in the course of his duties, employment, inquiry, inspection or investigation except in a proceeding under this Act.

Offence

55.-(1) Every person who,

.

- (c) contravenes any provision of this Act or the regulations,

and every director or officer of a corporation who knowingly concurs in such furnishing, failure or contravention is guilty of an offence and on summary conviction is liable to a fine of not more than \$10,000 or to imprisonment for a term of not more than one year, or to both. 1978, c.42, s.7(1).

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THE MINISTRY OF CORRECTIONAL SERVICES ACT, 1978, S.O. 1978, c.37.

[administered by the Ministry of Correctional Services]

PART I - Ministry of Correctional Services

Confidentiality

10. Every person employed in the administration of this Act, including any person making an inspection, investigation or inquiry under this Act, shall preserve secrecy in respect of all matters that come to his knowledge in the course of his duties, employment, inspection, investigation or inquiry and shall not communicate any such matters to any other person except,

- (a) as may be required in connection with the administration of this Act, the Parole Act (Canada), the Penitentiary Act (Canada), the Prisons and Reformatories Act (Canada) or the Criminal Code (Canada) or the regulations thereunder;
- (b) to the Ombudsman of Ontario or Correctional Investigator of Canada;
- (c) in statistical form if the person's name or identity is not revealed therein;
- (d) with the approval of the Minister.

No offence section.

THE MINISTRY OF TREASURY AND ECONOMICS ACT, 1978, S.O. 1978, c.62.

[administered by the Ministry of Treasury and Economics]

Oath of secrecy

15. Every person who is to examine the accounts or inquire into the affairs of any ministry pursuant to this Act shall be required to comply with any security requirements applicable to, and to take an oath of secrecy required to be taken by, persons employed in that ministry.

PART VIII - Enforcement

Information confidential - compellability, civil suit - power of Director to disclose

34.-(1) Except for the purposes of this Act and the regulations or as required by law,

- (a) an inspector, a person accompanying an inspector or a person who, at the request of an inspector, makes an examination, test or inquiry, shall not publish, disclose or communicate to any person any information, material, statement, report or result of any examination, test or inquiry acquired, furnished, obtained, made or received under the powers conferred under this Act or the regulations;
- (b) no person shall publish, disclose or communicate to any person any secret manufacturing process or trade secret acquired, furnished, obtained, made or received under the provisions of this Act or the regulations;
- (c) no person to whom information is communicated under this Act and the regulations shall divulge the name of the informant to any person; and
- (d) no person shall disclose any information obtained in any medical examination, test or x-ray of a worker made or taken under this Act except in a form calculated to prevent the information from being identified with a particular person or case.

(2) An inspector or a person who, at the request of an inspector, accompanies an inspector, or a person who makes an examination, test, inquiry or takes samples at the request of an inspector, is not a compellable witness in a civil suit or any proceeding, except an inquest under The Coroners Act, 1972 respecting any information, material, statement or test acquired, furnished, obtained, made or received under this Act or the regulations.

(3) A Director may communicate or allow to be communicated or disclosed information, material, statements or the result of a test acquired, furnished, obtained, made or received under this Act or the regulations.

PART IX - Offences and Penalties

37.-(1) Every person who contravenes or fails to comply with,

(a) a provision of this Act or the regulations;

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is guilty of an offence and on summary conviction is liable to a fine of not more than \$25,000 or to imprisonment for a term of not more than twelve months, or to both.

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(3) In a prosecution of an offence under any provision of this Act, any act or neglect on the part of any manager, agent, representative, officer, director or supervisor of the accused, whether a corporation or not, shall be the act or neglect of the accused.

THE OMBUDSMAN ACT, 1975, S.O. 1975, c.42.

[administered by the Office of the Assembly]

Oath of office and secrecy - disclosure

13.-(1) Before commencing the duties of his office, the Ombudsman shall take an oath, to be administered by the Speaker of the Assembly, that he will faithfully and impartially exercise the functions of his office and that he will not, except in accordance with subsection 2, disclose any information received by him as Ombudsman.

(2) The Ombudsman may disclose in any report made by him under this Act such matters as in his opinion ought to be disclosed in order to establish grounds for his conclusions and recommendations.

19.

(2) Every investigation by the Ombudsman under this Act shall be conducted in private.

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Secrecy - protection - disclosure not required

20.

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(3) Subject to subsection 4, no person who is bound by the provisions of any Act, other than The Public Service Act, to maintain secrecy in relation to, or not to disclose, any matter shall be required to supply any information to or answer any question put by the Ombudsman in relation to that matter, or to produce to the Ombudsman any document or thing relating to it, if compliance with that requirement would be in breach of the obligation of secrecy or non-disclosure.

(4) With the previous consent in writing of any complainant, any person to whom subsection 3 applies may be required by the Ombudsman to supply information or answer any question or produce any document or thing relating only to the complainant, and it is the duty of the person to comply with that requirement.

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20.-(6) Except on the trial of any person for perjury in respect of his sworn testimony, no statement made or answer given by that or any other person in the course of any inquiry by or any proceedings before the Ombudsman is admissible in evidence against any person in any court or at any inquiry or in any other proceedings, and no evidence in respect of proceedings before the Ombudsman shall be given against any person.

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21.-(1) Where the Attorney General certifies that the giving of any information or the answering of any question or the production of any document or thing,

- (a) might interfere with or impede investigation or detection of offences;
- (b) might involve the disclosure of the deliberations of the Executive Council; or
- (c) might involve the disclosure of proceedings of the Executive Council or of any committee of the Executive Council, relating to matters of a secret or confidential nature, and would be injurious to the public interest,

the Ombudsman shall not require the information or answer to be given or, as the case may be, the document or thing to be produced.

Disclosure not required - proceedings privileged

21.-(2) Subject to subsection 1, the rule of law which authorizes or requires the withholding of any document, or the refusal to answer any question, on the ground that the disclosure of the document or the answering of the question would be injurious to the public interest does not apply in respect of any investigation by or proceeding before the Ombudsman.

25.

(2) The Ombudsman, and any such person as aforesaid, shall not be called to give evidence in any court, or in any proceedings of a judicial nature, in respect of anything coming to his knowledge in the exercise of his functions under this Act.

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THE ONTARIO GUARANTEED ANNUAL INCOME ACT, 1974, S.O. 1974, c.58.
[administered by the Ministry of Revenue]

Information confidential - disclosure

10.-(1) Except as provided in subsection 2, all information obtained under this Act by any officer, employee or agent of the Ministry of Revenue is privileged and confidential, and no such officer, employee or agent shall knowingly communicate or allow to be communicated to any person not legally entitled thereto any such information, or allow any person not legally entitled to do so to inspect or have access to any statement or other writing containing such information.

(2) Any information referred to in subsection 1 that is obtained by any officer, employee or agent of the Ministry of Revenue in the administration of this Act may be communicated to any officer or employee of the Department of National Health and Welfare of the Government of Canada or of the Department of National Revenue of the Government of Canada, or of the Ministry of Treasury, Economics and Intergovernmental Affairs, or of the Ministry of Community and Social Services, or to any person or class of persons prescribed by the Lieutenant Governor in Council and approved by the Minister of National Health and Welfare of the Government of Canada who are administering a program of assistance payments similar in nature to the payments authorized under this Act.

Evidence and production of documents - Offence

10.-(3) Notwithstanding any other Act or law, no officer, agent or employee of Her Majesty shall be required, in connection with any legal proceedings, to give evidence relating to any information that is privileged under subsection 1 or to produce any statement or other writing containing any such information.

(4) Subsections 1 and 3 do not apply in respect of proceedings relating to the administration or enforcement of this Act.

15.-(1) Every person who,

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(d) contravenes section 10...

is guilty of an offence and on summary conviction is liable to a fine of not less than \$50 and not more than \$300 for each offence.

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THE POLICE ACT, R.S.O. 1970, c. 351, as am. S.O. 1972, c.1.
[administered by the Ministry of the Solicitor General]

Disclosure of evidence taken in private at a Police Commission inquiry - penalty

57.

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(8) Where evidence is taken in private under subsection 4, no person, without the consent of the Commission, shall knowingly disclose any evidence so taken or the name of any witness so examined, and every person who contravenes this subsection is guilty of an offence and on summary conviction is liable to a fine of not more than \$2,000 or to imprisonment for a term of not more than one year, or to both.

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THE POLICE ACT continued

Causing disaffection, etc. - Offence

69.-(1) Every person, including a member of a police force, who,

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- (b) induces or attempts to induce, or does any act calculated to induce, a member of a police force to withhold his services or commit a breach of discipline;

.

is guilty of an offence and on summary conviction is liable to a fine of not more than \$500 or to imprisonment for a term of not more than one year, or to both.

(2) No prosecution shall be instituted under this section without the consent of the Solicitor General. 1972, c.l,s.97(2).

(3) Where a person convicted of an offence under subsection 1 is a member of a police force, he shall,

- (a) cease to be a member and shall not thereafter be appointed to any police force; and
- (b) subject to any agreement with or by-law of the municipality, forfeit all pension rights under any pension scheme of such police force except his right to receive such moneys as he has paid into any fund under the scheme with interest at the rate payable under the scheme.

R.R.O. 1970, Regulation 680 - PART I, Municipal Police Forces

[Note: Part II dealing with the Ontario Provincial Police Force makes the code applicable to the OPP and contains penalty provisions identical to ss.16 and 20 below]

Code - offences

- 4. The code applies to every police force.

16.

- (4) A person found guilty of a minor offence is liable to,
- (a) an admonition; or
 - (b) forfeiture of leave or days off not exceeding five days; or
 - (c) forfeiture of pay not exceeding three days pay.

.

20.

- (2) A person found guilty of a major offence is liable to,
- (a) dismissal; or
 - (b) be required to resign, and in default of resigning within seven days, to be summarily dismissed from the force; or
 - (c) reduction in rank or gradation of rank; or
 - (d) forfeiture of leave or days off not exceeding twenty days; or
 - (e) forfeiture of pay not exceeding five days pay; or
 - (f) a reprimand, which may be imposed in lieu of or in addition to any other punishment imposed.

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SCHEDULE - Code of Offences

1. Any chief of police, other police officer or constable commits an offence against discipline if he is guilty of,

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v. Breach of Confidence, that is to say, if he,

- (a) divulges any matter which it is his duty to keep secret;

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- (c) without proper authority communicates to the public press or to any unauthorized person any matter connected with the police force;
- (d) without proper authority, shows to any person not a member of the police force or any unauthorized member of the force any book, or written or printed paper, document or report that is the property of the police force;

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THE PRIVATE INVESTIGATORS AND SECURITY GUARDS ACT, R.S.O. 1970, c.362.

[administered by the Ministry of the Solicitor General]

Information confidential - Offences

18. Any information received by the Registrar or the Commissioner in connection with an application or a record or return required under this Act or in the course of an inquiry or investigation authorized by this Act shall not be disclosed without the consent of the Commissioner.

24. No person shall divulge to anyone, except as is legally authorized or required, any information acquired by him as a private investigator.

32.-(1) Every person who,

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(c) contravenes any provision of this Act or the regulations,

is guilty of an offence and on summary conviction is liable to a fine of not more than \$2,000 or to imprisonment for a term of not more than one year, or to both.

(2) Where a corporation is convicted of an offence under subsection 1, the maximum penalty that may be imposed is \$25,000 and not as provided therein.

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THE PUBLIC SERVICE ACT, R.S.O. 1970, c.386.

[administered by the Chairman of the Management Board of Cabinet]

Oath of Office and Secrecy

10.-(1) Every civil servant shall before any salary is paid to him take and subscribe before the Clerk of the Executive Council, his deputy minister, or a person designated in writing by either of them, an oath of office and secrecy in the

THE PUBLIC SERVICE ACT continued

following form:

I,....., do swear that I will faithfully discharge my duties as a civil servant and will observe and comply with the laws of Canada and Ontario, and, except as I may be legally required, I will not disclose or give to any person any information or document that comes to my knowledge or possession by reason of my being a civil servant.

So help me God.

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(3) A Minister may require any person or class of persons appointed to the unclassified service in any ministry over which he presides to take and subscribe either or both of the oaths set out in subsections 1 and 2.

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THE PUBLIC TRUSTEE ACT, R.S.O. 1970, c.389, as am. S.O. 1971, Vol.2, c.50.
[administered by the Ministry of the Attorney General]

Confidentiality

18. Every person employed in the performance of the duties imposed upon the Public Trustee by this or any other Act or by the Lieutenant Governor in Council shall preserve secrecy with respect to all matters that come to his knowledge in the course of such employment and shall not communicate any such matters to any person other than to a person legally entitled thereto or to his legal counsel except as may be required in connection with the administration of this Act and the regulations under this Act or any proceedings thereunder. S.O. 1971, Vol.2, c.50, s.73(3).

THE STATISTICS ACT, R.S.O. 1970, c.443.
[administered by the Ministry of Treasury and Economics]

Oath of office and secrecy - no unauthorized disclosure -
answers to be confidential

4.-(1) No person shall collect, compile, analyse or publish statistical information under this Act until he takes and subscribes before his minister, his deputy minister, or a person designated in writing by either of them, an oath of office and secrecy in the following form:

I,....., do swear that I will faithfully discharge my duties under The Statistics Act and, except as I may be legally required, I will not disclose or give to any person any information or document that comes to my knowledge or possession by reason of my duties under The Statistics Act. So help me God.

(2) Subject to section 6, no public servant having knowledge of the answers to questions asked in a questionnaire under this Act shall disclose or give to any person any information or document with respect to such answers without the written permission of his minister, and, except where statistical information is collected jointly under this Act, such permission shall be limited to the disclosing or giving of information or documents to public servants in the minister's department or in prosecutions instituted for offences against this Act.

(3) Notwithstanding anything in this Act, no minister or public servant shall, in any way, use the answers to questions asked in a questionnaire authorized under this Act for any purpose other than the purposes of this Act.

.

Disclosure of information to another department

6.-(1) Where a person who has answered a question in a questionnaire consents in writing, a minister may give permission to a public servant in his department who has knowledge of the answer to disclose or give the answer to one or more public servants in another department.

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THE STATISTICS ACT continued

Offences - unauthorized disclosures - affecting market value - speculating

8. Any person who,

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(b) discloses or gives any information or document to any person in contravention of subsection 2 of section 4,

is guilty of an offence and on summary conviction is liable to a fine of not more than \$300 or to imprisonment for a term of not more than six months, or to both.

9. Any person who,

(a) discloses or gives any information or document respecting an answer to a question in a questionnaire authorized under this Act to any person with the intent that the market value of a product is thereby affected; or

(b) uses an answer in any such questionnaire for the purpose of speculating in a product,

is guilty of an offence and on summary conviction is liable to a fine of not more than \$5,000 or to imprisonment for a term of not more than five years, or to both.

THE TRAINING SCHOOLS ACT, R.S.O. 1970, c.467, as am. S.O. 1978, c.66.

[administered by the Ministry of Community and Social Services]

O. Reg. 384/79.

Confidentiality

4. The Area Administrator shall keep the following records:

1. A confidential record containing all personal information on each ward.

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No Penalty

["'Area Administrator' means one or more employees of the Ministry appointed by the Minister as an Area Administrator for the purposes of this Act."]

THE VITAL STATISTICS ACT, R.S.O. 1970, c.483, as am. S.O. 1973, c.114.

[administered by the Ministry of Consumer and Commercial Relations]

[Note: Sections 11, 12 and 24 deal with the sealing up of birth registrations on identification of foundlings, inter-marriage of parents and adoption]

Copying of death certificate

17.

(5) No person shall make a copy or a duplicate of the medical certificate of death, nor shall any person receive a copy of the certificate, except as authorized by this or any other Act or the regulations made thereunder. 1973, c.114, s.5.

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[Information filed with the Registrar includes references to: previous pregnancies and births; particulars of births such as multiplicity, congenital anomalies and birth injuries; parentage; transsexual surgery; causes of still-birth & causes of death]

Certificates and Searches

38.-(1) A birth certificate shall contain only the following particulars of the registration:

- (a) name of the child;
- (b) date of birth;
- (c) place of birth;
- (d) sex;
- (e) date of registration; and
- (f) registration number.

(2) A death certificate shall only contain the following particulars of the registration:

- (a) name, age and marital status of the deceased;
- (b) date of death;
- (c) place of death;
- (d) sex;
- (e) date of registration; and
- (f) registration number.

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Certificates and Searches (cont'd)

39.-(1) Upon application and upon payment of the prescribed fee, any person who furnishes substantially accurate particulars, and satisfies the Registrar General as to his reason for requiring it, may obtain from the Registrar General a birth certificate in respect of any birth of which there is a registration in his office.

(2) Upon application and upon payment of the prescribed fee, any person may obtain from the Registrar General a death certificate in respect of any death of which there is a registration in his office.

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[Under s.43, a person who satisfies the Registrar General as to his reasons for requiring it, may ascertain the existence of the registration and the registration number of any birth, death, marriage, still-birth, divorce, adoption or change of name. See also The Children's Law Reform Act, 1977, S.O. 1977, c.41, s.12, which permits the filing of statutory declarations of paternity and access thereto by "any person having an interest"; and s.13, which provides access to similar declarations (and mother's statement that her husband is not the father) filed under s.6 of The Vital Statistics Act, to a person "who has an interest, furnishes substantially accurate particulars and satisfies the Registrar General as to his reason for requiring it"; and s.14 which requires courts to file findings of parentage with the Registrar General which are open to inspection by "any person"; statements under ss.12 & 14 of The Children's Law Reform Act, 1977 contain the birthdate, citizenship and SIN of the father, the names and addresses of the father and mother, and the names, sex, date and place of birth and birth registration number of the child.]

Secrecy - statistics excepted

48.-(1) No division registrar, sub-registrar, funeral director or person employed in the service of Her Majesty shall communicate or allow to be communicated to any person not entitled thereto any information obtained under this Act, or allow any such person to inspect or have access to any records containing information obtained under this Act.

THE VITAL STATISTICS ACT continued

Secrecy - statistics excepted (cont'd)

48.-(2) Nothing in subsection 1 prohibits the furnishing and publication of information of a general statistical nature that does not disclose information about any individual person.

Breach of secrecy provision - General offence

52. Any person contravening any of the provisions of section 48 is guilty of an offence and on summary conviction is liable to a fine of not more than \$200.

53. Every person guilty of any act or omission in contravention of this Act for which no penalty is otherwise provided is guilty of an offence and on summary conviction is liable to a fine of not more than \$100.

R.R.O. 1970, Regulation 820.

Access to and information from records

66.-(1) The Regional Director of Family Allowances for Canada may have access to or may be given information from the records in the Registrar General's office but only after he has taken an oath of secrecy in Form 30.

(2) A representative of Canada, duly authorized in writing, may have access to or may be given information from the records in the Registrar General's office but only after he has taken an oath of secrecy in Form 30.

(3) A representative of Ontario or another province, duly authorized in writing, may be given information from the records in the Registrar General's office but only after he has taken an oath of secrecy in Form 30.

(4) Upon application to the Registrar General, a representative of another state or country may be given information from the records in the Registrar General's office but only after he has taken an oath of secrecy in Form 30.

(5) The medical officer of health of a municipality or health unit, as the case may be, may be given information from

THE VITAL STATISTICS ACT continued

the records in any division registrar's office but only after he has taken an oath of secrecy in Form 30.

(6) Any officer, clerk or servant of a board of health who is designated in writing for the purpose by the medical officer of health may be given information from the records in the office of the division registrar but only after he has taken an oath of secrecy in Form 30.

(7) Any officer or clerk in the Department of Health, named in writing by the Deputy Minister of Health for the purpose, may have access to, or be given information from, the records in the Registrar General's office or in any division registrar's office but only after he has taken an oath of secrecy in Form 31.

(8) A member of a police force of a municipality within Ontario may be given information from the records in the Registrar General's office, but only after he has taken an oath of secrecy in Form 30.

(9) A representative of a children's aid society approved by the Lieutenant Governor in Council under The Child Welfare Act, may be given information from the records in the Registrar General's office, but only after he has taken an oath of secrecy in Form 30.

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Form 30 - The Vital Statistics Act
OATH OF SECRECY

I, _____
 (given names)

 (surname)

solemnly swear that I will hold secret and will not disclose to any person any information given me from the records in the Registrar General's office or obtained from those records by reason of my access thereto except information required in the performance of the duties of my office or information required by a court of law for the purposes of an action, prosecution or other proceeding.

SWORN before me at the
of in the
of, this ... day of, 19..
.....
.....

(signature of deponent)

A Commissioner, etc.

R.R.O. 1970, Reg. 820, Form 30.

THE VITAL STATISTICS ACT continued

R.R.O. 1970, Regulation 820 (cont'd)

Form 31 - The Vital Statistics Act
OATH OF SECRECY

I,
(given names)
.....
(surname)

solemnly swear that I will hold secret and will not disclose to any person any information given me from the records in the Registrar General's office or in any division registrar's office or obtained from those records by reason of my access thereto, except to the Director of Industrial Hygiene or the Medical Statistician of the Department of Health.

SWORN before me at the
of in the
.....of, (signature of deponent)
this day of....., 19..
.....

A Commissioner, etc.

R.R.O. 1970, Reg. 820, Form 31.

THE WORKMEN'S COMPENSATION ACT, R.S.O. 1970, c.505, as am. S.O. 1973, c.173.

[administered by the Ministry of Labour]

PART I - Compensation

Compellability in a civil suit

81a.-(1) No commissioner of the Board, or any other commissioner or officer or employee of the Board, or a person who is engaged by the Board to conduct an examination, test or inquiry or authorized to perform any function, shall be required to give testimony in any civil suit or proceeding to which the Board is not a party respecting any information, material, statement or result of any examination, test or inquiry acquired, furnished, obtained, made or received in the performance of his duties under this Act.

Compellability in a civil suit (cont'd)

81a.-(2) Neither the Board, a commissioner thereof or any other commissioner, an officer or employee of the Board or a person who is engaged by the Board to conduct an examination, test or inquiry or authorized to perform any function, shall be required to produce in a civil suit to which the Board is not a party a document, extract, report, material or statement acquired, furnished, obtained, made or received in the performance of his duties under this Act. 1973, c.173, s.8.

.

Privileged Information - Offence

98.-(1) No officer of the Board and no person authorized to make an inquiry under this Part shall divulge or allow to be divulged, except in the performance of his duties or under the authority of the Board, any information obtained by him or that has come to his knowledge in making or in connection with an inspection or inquiry under this Part.

(2) Every person who contravenes any of the provisions of subsection 1 is guilty of an offence and on summary conviction is liable to a fine of not more than \$50.

Reports privileged

99. Every report made under section 52 and every other report made or submitted to the Board by a physician, surgeon, hospital, nurse, dentist, drugless practitioner, chiropodist or optometrist is for the use and purposes of the Board only, is deemed to be a privileged communication of the person making or submitting the same, and unless it is proved that it was made maliciously, is not admissible as evidence or subject to production in any court in an action or proceeding against such person.

Survey of Health Insurance Systems

The examination of the internal operation of the Ontario Health Insurance Plan and the questions which it raised regarding the collection, storage and dissemination of confidential information for health-insurance claims processing provoked our interest in other Canadian jurisdictions. We decided to attempt to determine how other computerized health-insurance systems manage the difficult tasks of controlling and protecting massive quantities of identifiable health-insurance data. To this end a simple questionnaire was designed containing 24 questions about various stages of the claims processing system, and in August, 1979, it was distributed to the other nine provinces, the territories and to a few Ontario private health insurance plans. The response was gratifying, for although the territories did not return the completed questionnaire, replies were received from all provinces except New Brunswick and from two private plans, namely Cumba and Green Shield Prepaid Services Inc.

Because of the length of the questionnaire and the number of inclusions made by the various respondents, no attempt has been made to reproduce fully all the answers received. Instead, a table has been prepared summarizing the answers to 13 of the 24 questions asked on the original survey form. The answers charted are, for the most part, direct quotations, although if an external document was included in answer to a question some amount of subjective judgment was necessary to interpret the response. The purpose of the table is simply to provide an objective source of information by setting out the pertinent characteristics of every plan included in a manner that invites easy comparison.

Two short notes on the comparative health insurance table are in order. All of the responses from the provinces charted relate only to their respective medical insurance programmes and not to their hospitalization benefits plan, the one exception being the answers tabled for Prince Edward Island, which utilizes the same claims processing system for all of its physician and hospital claims. Green Shield Prepaid Services Inc., a private Ontario health plan, generously completed 3 separate questionnaires, one for its dental claims, one for

those relating to vision and audio services, and one concerned with its prescription drug plan, as each of these sections is different in its method of operation. For purposes of comparison the description of Green Shield's operation is limited to its "Apoth-A-Care" Prescription Drug Plan, the division which handles the largest number of claims and, it could be argued, the most sensitive type of health information of the three submitted.

The symbol "x" denotes a positive response.

HEALTH PLAN QUESTION	BRITISH COLUMBIA MEDICAL SERVICES PLAN	ALBERTA HEALTH CARE INSURANCE PLAN	SASKATCHEWAN MEDICAL CARE INSURANCE COMMISSION	MANITOBA HEALTH SERVICES COMMISSION
1. How many individuals are registered in your health plan?	2,500,000	2,100,000	977,580	1,098,904
2. How many claims are handled, on average, per month?	1,600,000	1,270,000	473,000	500,000
3. Which the the following health data is collected on the claims submission document?				
-the patient's name	x	x	x	x
-the subscriber's name			x	
-address	for few claims		x	x
-age			x	x
-diagnosis	x	x	x	x
-diagnostic code		x	x	x
-physician's name	x	x	x	x
-referring physician	x	x	x	x
-date of service	x	x	x	x
-fee billed	x	x	x	x
-fee paid		x		
-clinic name or number	x	x	x	x
-hospital name or number	x			x
-subscriber number	x	x	x	x
-fee schedule code	x	x	x	x
4. What is the disposition of source documents following computer entry?				
-retained (if so,how long?)	2 months, off premises 2 yrs.	4 years	16 weeks after a claim is paid	4-6 months
-disposed of (if so, how?)	Shredded	Shredded	Shredded	Incineration
5. If claims submission documents are microfilmed, what is the disposition of the microfilm?	Disposed of after 7 years	Retained indefinitely under secure conditions	Retained for 2 years plus the current year	Retained indefinitely
6. a)What computer facilities does your plan utilize?				
-computer dedicated to the use of health insur. plan				
-computer time shared with other govt. ministries	x	x	x	x
-computer time shared with private organizations				
-computer shared within the Ministry of Health				
b)Are any external organizations utilized for data input?	No	Yes	No	No
c)If yes, are they:				
-private companies		x		
-government agencies				
7. a)Does the computer produce a claims history file for each patient or subscriber?	Yes	Yes	Yes	Yes

REGIE DE L'ASSURANCE- MALADIE DU QUEBEC	NOVA SCOTIA MEDICAL SERVICES INSURANCE	PRINCE EDWARD ISLAND HOSPITAL AND HEALTH SERVICES COMMISSIONS	NEWFOUNDLAND MEDICAL CARE COMMISSION	ONTARIO PRIVATE PLANS	
				CUMBA	GREEN SHIELD PREPAID SERVICES INC.
6,200,000	813,000	123,000 Total Population	600,000	150,000	150,000
3,950,000	462,000	Phys 45-48,000 Hosp 12-13,000	166,000	9,000	100,000
x	x	x & Pat.'s SIN	x	x	x
				x	
If pay benefic.	x	x		x	
Date of birth	x	x	x	Dent. plan only	
x	x	x	Dr.'s remarks	Dr.'s remarks	
x		x	x	Procedure code	Drug code
x	x	x	x	x on drug Rx	x
x	x	x	x		
x	x	x	x		x
	x	x			
	x		x		Pharmacy no.
x	x		x	x - some	
Pat.no./grp.no.	Patient no.			x	x
x	x	x	x		
For 12 months after microfilm	90 days	Original & 2 copies retained	3 months	7 yrs., others returned to subscriber	2 to 3 years
Chemically- outside company -but witnessed	Shredded	Shredded	Incineration	Incineration	Recycled paper
1 copy kept at Brinks;1 copy used daily for info. retrieval	Retained indefinitely	Retained on premises	Only copy stored on premises	Not applicable	Not applicable
x					x
	x	x	x - Operated by crown corp.		
	x			x	
No	Yes	No	No	No	No
	x				
	x				
Yes	Yes	No, although computer has capability	Yes, printout only on request	No	Yes, multiple files access- ible to build record

HEALTH PLAN QUESTION	BRITISH COLUMBIA MEDICAL SERVICES PLAN	ALBERTA HEALTH CARE INSURANCE PLAN	SASKATCHEWAN MEDICAL CARE INSURANCE COMMISSION	MANITOBA HEALTH SERVICES COMMISSION
7. b) If yes, which of the following data is included:				
-the patient's name	x			x
-the subscriber's name				
-subscriber/patient no.	x	x	x	x
-clinic name				
-clinic number	x	x	x	
-fee service code	x	x	x	x
-diagnosis				
-diagnostic code		x	x	x
-physician's name				
-physician's number	x	x	x	x
-referring physician's no.	x	x	x	x
-date of service	x	x	x	x
-fee billed	x	x	x	
-fee paid	x	x	x	x
-other	x	x-Including sex and internal ID codes	x-Including patient's birthdate & sex	x-Including patient's birth year & sex
8. a) Are any of the following files created from the master file?				
-enrollment/register'n file	x			
-premium assistance file	x			
-delinquent file	x			
-subrogation file				x-3rdparty file
-communicable disease reg.				
b) If yes to a) describe what medical information is collected for each type of file.	No medical information- only coverage information			Type of service, diagnosis
9. a) How are records in the health plan identified?				
-name	x	x		x
-assigned number	x	x	x	x
-number derived elsewhere e.g. Social Insurance No.				
-other				Birthdate, sex
b) If an identifying no. is assigned, it is given to:				
-subscriber				x
-each patient	x			
-subscriber with individual patient suffix no.		x	x	
-group				
-other				
10. a) Are any verification of service letters sent to:				
-subscriber		x	x	x
-patient	x	x	x	x
b) Is the verification letter ever sent to the patient who is not the subscriber?	All letters sent to patient If minor, parent asked to sign statement.	Letters directed to either the patient or registrant.	When beneficiary reaches 18 yrs., receives own number and letter.	Statements sent only to subscriber, never to dependant.
c) Does the verification letter contain:				
-diagnosis				
-type of service	x	x	x	x
-name of physician	x	x	x	x
-date of service	x	x		x
-other		Patient ID, amount paid	Registration no., amount paid	Amount paid

REGIE DE L'ASSURANCE- MALADIE DU QUEBEC	NOVA SCOTIA MEDICAL SERVICES INSURANCE	PRINCE EDWARD ISLAND HOSPITAL AND HEALTH SERVICES COMMISSIONS	NEWFOUNDLAND MEDICAL CARE COMMISSION	ONTARIO PRIVATE PLANS	
				CUMBA	GREEN SHIELD PREPAID SERVICES INC.
	x				x
x	x		x		x
Hospital no.					Pharmacy name
x	x		x		Pharmacy no.
x	x		x		Drug code
x	x		x		
?	x				
x	x		x		x
	x				
x	x		x		x
x-Group number, claims number (ext. & int.)	x-Referral information, payment cycle		x-Claim and reference number		
		x	x-Printed out	x	x
		No medical information in registra- tion file	None. Only name of applicants, address, d.o.b, resident status	None	None
x	x			x	
x	x		x	x	x
x S.I.N.		x S.I.N.			
				x	x
x		x S.I.N.	x		
	x				
				x	x
x	x	x	x		x
?	For minors, letter usually sent to head of family	All letters sent to patient except in cases of children un- der 16 years	Individually registered ben- eficiaries; under 16, letter sent to parent		
x	x				
x	x	x	x		x
x		x	x		
	Cost of service	Patient's S.I.N.	Health Insurance No.		Supplementary information

HEALTH PLAN QUESTION	BRITISH COLUMBIA MEDICAL SERVICES PLAN	ALBERTA HEALTH CARE INSURANCE PLAN	SASKATCHEWAN MEDICAL CARE INSURANCE COMMISSION	MANITOBA HEALTH SERVICES COMMISSION
10. d) In which circumstances if any, are verification letters suppressed? -service related to pregnancy, incl. abortion, sterilization, etc. -venereal disease care -any service if patient or service provider requests -other services	x		x-For children under 18	x-For dependent female children
		x	x	x
	Psychiatric services not specified-listed under 'sundry'	Sensitive medical situation or family problem		
e) How are the persons to whom the letters are sent selected?	Randomly	Sent to all registrants semi-annually; patients selected through internal audit	Move sequentially through file selecting a specific no. of beneficiaries & services each month	Random sampling of 5% of total monthly volume
f) Is any other method of claims verification employed?		Specific patients are contacted in some circumstances	Beneficiaries may be contacted about selected services for a particular doctor.	Manual, visual and computer edits
11. a) Is there any individual or group responsible for the security of files? b) Is computer file security protected by: -password -encryption -other		Yes	Claims branch	Yes
		x(some)	x(on disk file)	x
			Account no. & tape library on tape files	
12. Which of the following uses are made of health data collected for insurance claims processing? -processing insurance claims -medical research -administrative statistics for Ministry of Health -health practitioner registry -other	x	x	x	x
		x	x	x
	x	x	x	x
		x	x	x
				Program development & assessment
13. Is there a written policy or regulation concerning the confidentiality of information within the plan?	Yes. "Minute of the Commission"	Yes. The Alberta Health Care Insurance Act section 25	Yes. The Saskatchewan Medical Care Insurance Act section 37	Yes. Inter-departmental memo

REGIE DE L'ASSURANCE- MALADIE DU QUEBEC	NOVA SCOTIA MEDICAL SERVICES INSURANCE	PRINCE EDWARD ISLAND HOSPITAL AND HEALTH SERVICES COMMISSIONS	NEWFOUNDLAND MEDICAL CARE COMMISSION	ONTARIO PRIVATE PLANS	
				CUMBA	GREEN SHIELD PREPAID SERVICES INC.
x-All gynecological services	x-If single or under 18	x			
x		x			
Hosp. surgery, toxicomanias, children under 1 year, male genital system under 25 years	Psychiatric di- agnosis, wards of Children's Aid, d.o.a., still-births, senior patients	Psychiatric illness, senior patients			
On the basis that each health profes- sional be ver- ified once a year	Random sampling (1%)	Random selection	Random		Random sampling
May occur during the study of pro- files of practice	Occasionally through audit of provider records	Hospital services matched against physician claim (in-patient/ out-patient)	Review of re- ports and hos- pital admission separation slips	If claim costs doubtful, con- tact pharmacist or dentist	Pharmacy audits
Yes	Yes	Each employee responsible	Group (each division is a group)	Office manager	Yes
x	x	x	x	Not applicable	x
x	x	x	x	x	x
	x	x			
x	x	x	x		
x	?				
Negot. between health profess. associations & Min. of Social Affairs, pro- file of prac- tice, peer re- view committees	Fee negotiations				
Yes. A general & an operation- al policy; The Health Insur- ance Act sections 50-55	Yes. Health Services and Insurance Act	Yes. Health Services Pay- ment Act and Regulations	Yes. In-house security memo; civil service oath of secrecy	No. Verbal instructions given periodic- ally; employ- ees informed when hired.	Yes. Service Agreement

APPENDIX IV

Appearances at Hearings

Investigative Hearings

WITNESS	OCCUPATION	DATE
Elizabeth Aboud	Director, Disability Policy, Civil Service Commission	March 13, 1979
Bruce Gerald Russell Adams	OHIP employee, retired	October 30, 1978
Robert Hailey Addington	Claim Clerk, OHIP, London	October 30, 1978
Donald E. Aitchison	Claims Manager, Toronto Branch, Lumbermens Mutual Casualty Company	June 1, 1978
Dr. Marguerite Archibald	Medical Officer of Health, City of North York	March 7, 1979
Herman Jonathon Arkelian	District Director, OHIP, Oshawa	October 20, 1978
Ronald James Arnold	Private Investigator, Ron Arnold and Associates Incorporated	May 23, 1978
Dr. Reginald Dolan Atkinson	Mutual Life Assurance Company of Canada	March 6, 1979
Thomas Hutchinson Backhouse	District Director, OHIP, Ottawa	November 1, 1978

WITNESS	OCCUPATION	DATE
W. Alan Backley	Deputy Minister of Health	November 21, 1978
David George Baker	Director of Personnel, Hotel Dieu of St. Joseph Hospital, Windsor	August 22, 1978
Perla Baldemor	Clerk, Medical Records Department, The Wellesley Hospital, Toronto	June 14, 1978
Pauline Agnes Baldwin	Head, Medical Records Department, Hotel Dieu of St. Joseph Hospital, Windsor	August 22, 1978
Lewis Alexander Balsdon	Member, Therapeutic Abortions Committee, St. Thomas-Elgin General Hospital	February 7, 1979
Ellen Elizabeth Barnes	Director, Medical Records Department, The Wellesley Hospital, Toronto	June 15, 1978
Stanley John Barnes	Supervisor, Common Services, OHIP, Mississauga	October 30, 1978
Dr. Glenn S. Bartlett	Chief of Staff, Toronto East General and Orthopaedic Hospital	January 30, 1979
Robert Desmond Beaman	Director, Hospital Claims, OHIP	November 17, 1978
Brian Bechard	Divisional Claims Superintendent, State Farm Mutual Automobile Insurance Company	August 2, 1978

WITNESS	OCCUPATION	DATE
Rachel Benmurgi	Supervisor, Hospital Claims, OHIP	November 6, 1978
Dr. Joseph Berkeley	Physician	August 18, 1978
Raymond Grant Berry	Director, Program Development Branch, Ministry of Health	February 6, 1979
Jean Binnell	Physiotherapist, North York General Hospital	August 2, 1978
P. B. Blewett	Executive Director, University Hospital, London	June 30, 1978
Albert William Board	District Director, OHIP, Hamilton	October 18 & 19, 1978
Derek Ian Bonner	Insurance Adjuster, A. I. MacFarlane and Associates Limited	May 11 & 15, 1978
Dr. Adrian Joseph Borre	President, Medical Staff, St. Thomas- Elgin General Hospital	February 7, 1979
Paul Bracken	Adamson's Insurance Adjusters Limited	June 2, 1978
Herbert Roy Brereton	Equifax Services Limited (formerly, Retail Credit Company of Canada Limited)	July 27, 1978
Robert Albert Clark Britnell	Equifax Services Limited (formerly, Retail Credit Company of Canada Limited)	July 28 & 31, 1978

WITNESS	OCCUPATION	DATE
James Broderick	Assistant Executive Director, Windsor Western Hospital Centre, Inc.	August 22, 1978
Michael Joseph Brousseau	Claims Manager for Ontario, The Wawanesa Mutual Insurance Company	May 17, 1978
James Arthur Bruce	Associate Administrator, North York Branson Hospital	May 1, 1978
David McColm Buchanan	Director, Insurance Claims Branch, OHIP	November 14 & 15, 1978
Burshuden Sarup Buhatnager	Formerly with Blood Bank, Toronto East General and Orthopaedic Hospital	January 30, 1979
Helen Bullock	Reporter, Toronto Star	February 12, 1979
Meiri Burn	Director, Medical Records, Victoria Hospital, London	June 30, 1978
Kathleen Bustine	Supervisor, Central Registry, Ministry of Health	February 13, 1979
Dr. Howard Cameron	Orthopaedic Surgeon	June 30, 1978
Mike Campbell	Union Representative, Ontario Public Service Employees Union (OPSEU)	January 30, 1978
John Russell Carlisle	Assistant Registrar, The College of Physicians and Surgeons of Ontario	November 22 & 23, 1978

WITNESS	OCCUPATION	DATE
Brian Dew Carter	OHIP, Subrogation Branch	August 3 & 4, 1978
Frank Chalmers	Assistant Executive Director, Metropolitan General Hospital, Windsor	August 22, 1978
Allan E. Chaplain	Claims Manager, OHIP, Thunder Bay	November 1, 1978
Ena Jane Chubb	Assistant Director, Medical Records, Queen Street Medical Health Centre, Toronto	November 22, 1978
Albert Ciampini	Corporal, OPP	April 20 & May 31, 1978
Margaret Ciupa	Chairman, Board of Trustees, Lakeshore Area Multi-Services Project (LAMP), Toronto	February 6, 1979
Robert Charles Clark	Man-Mate Services	January 23, 1979
Randall Bruce Claxton	Inspector, RCMP	November 27 & 29, 1978
Dr. Robert Colcleugh	Plastic Surgeon	June 30, 1978
Dr. Peter Neil Cole	Director, Family Planning Service, Department of Health, City of Toronto	March 13, 1979
Barbara Helen Coleman	Medical Receptionist	August 18, 1978
Charles Robert Coleman	Executive Director, Hospital Medical Records Institute (HMRI)	January 17, 1979

WITNESS	OCCUPATION	DATE
Joseph Comisky	Vice-President, Claims Manager, Pilot Insurance Company	August 8, 1978
Douglas Augustus Coombs	District Supervisor, OHIP, Kitchener	October 20, 1978
Lewis Martin Coray	Detective, London Police Force	October 18, 1978
Michael Joseph Cortese	Cortlaw Services Limited	June 27 & 28, 1978
Barbara Coyne	Co-ordinator, Lawrence Heights Medical Centre, Toronto	February 5, 1979
Victor Crew	Director, Human Resources Management Branch, Ministry of Cor- rectional Services	March 8, 1979
Roy Crocker	Private Investigator, Equifax Services Limited (formerly, Retail Credit Company of Canada Limited)	July 26 & 27, 1978
Cy Crossley	Claims Analyst, Chrysler Canada Limited	August 18, 1978
Margaret Elizabeth Crowley	Clerk, Social Services, City of Windsor	August 21, 1978
Audrey Cummins	Supervisor, Venereal Disease Section, Ministry of Health	February 8, 1979

WITNESS	OCCUPATION	DATE
William Cunningham	Assistant Vice-President, Fireman's Fund Insurance Company of Canada (formerly, Shaw and Begg Limited)	May 17, 1978
Arthur F. Daniels	Executive Director, Community Programs, Ministry of Correctional Services	March 8, 1979
Douglas Andrew DaSilva	Supervisor, Administrative Support Services, OHIP, London	October 19, 1978
Gerald Donald Davies	Private Investigator, Canadian Claims Research Association (C.C.R.)	September 15, 1978
James Michael Davis	Director, OHIP, London	October 30, 1978
Gregory Allen Dawson	Document Examiner, Centre of Forensic Sciences	December 4, 1978
Stanley C. Day	Manager, Administrative Services, OHIP, Windsor	November 1, 1978
James Michael Delaney	OHIP, Mississauga	October 30, 1978
Eleanor Jean Louise Dienum	Medical Director, London Psychiatric Hospital	March 5, 1979
Ann Doucette	Medical Records Librarian, Toronto East General and Orthopaedic Hospital	January 30, 1979

WITNESS	OCCUPATION	DATE
Ross Dowson	Citizen	March 28, 1979
Richard James Doyle	Editor-in-Chief, The Globe and Mail	December 6, 1978 & January 15, 1979
Dr. Carl Kenneth Dresser	Physician, Lawrence Heights Medical Centre, Toronto	January 23, 1979
Barbara Dube	Secretary, Windsor Western Hospital Centre, Inc.	August 22, 1978
John Brian Duff	Private Investigator, formerly with Canadian Claims Research Association (C.C.R.)	September 14, 1978
Albert Duguid	Assistant Commissioner, OPP	February 1, 1979
David Harold Eisenhauer	Private Investigator	May 23 & 24, 1978
John Michael Ellis	Claims Manager, Eaton/Bay Insurance Company	May 16, 1978
Elona Eluk	Employee of Toronto East General and Orthopaedic Hospital	January 30, 1979
Glen Arthur Essery	Claims Analyst, Chrysler Canada Limited	August 18, 1978
Mary Anne Evans	Member, Board of Governors, St. Thomas-Elgin General Hospital	February 7, 1979
Ann Everist	Radiology Department, North York General Hospital	August 2, 1978

WITNESS	OCCUPATION	DATE
Frank James Farrell	Physiotherapist	August 22, 1978
Isabel Scotland Farrell	Receptionist for Mr. Farrell	August 22, 1978
Peter Feduik	Sergeant, Metropolitan Toronto Police	September 28, 1978
Edward Fedory	Administrator, Workmen's Compensation, Ford Motor Company of Canada Limited	August 18, 1978
Beryl Feeney	Accounts Receivable Clerk, In Patients, York-Finch General Hospital, Toronto	August 1, 1978
Frank J. Feld	OHIP, Thunder Bay	November 1, 1978
Robert Archie Ferguson	Assistant Commissioner, Special Services Division, OPP	November 21, 1978 & February 1, 1979
Romeo Fernandez	Manager, Common Services, Ministry of Health	February 12 & 13, 1979
Gordon Ellis Fetherston	General Manager, OHIP	November 15 & 16, 1978
Dr. E. Keith Fitzgerald	Medical Officer of Health, Borough of Scarborough	March 7, 1979
Carl Franco	Franco Investigation Services	June 2, 1978
Fred Freeman	Staff Sergeant, RCMP	September 28, 1978
Clifford Gerald Friday	Claims Manager, OHIP, Hamilton	October 19, 1978

WITNESS	OCCUPATION	DATE
Richard Furness	Reporter, The Globe and Mail	March 6, 1979
William Vine Galer	Claims Manager, OHIP, Oshawa	October 20, 1978
Alice Garner	Director, Medical Records, Toronto Western Hospital	November 30, 1978
Dorothy Garner	Supervisor, Central Inquiry Office, OHIP, Toronto	November 6, 1978
Solomon David Garshowitz	President, Medical Services Laboratories of Newmarket	January 16, 1979
Glen Allen Gartshore	Corporal, RCMP	June 8 & 9 & November 27, 1978
Ronald Frederick Gates	Supervisor of Employment, General Motors of Canada Limited, Scarborough	January 15, 1979
Chester Gibula	Assistant Claims Manager, Consti- tutional Insurance Company of Canada	August 2, 1978
Richard Thomas Godden	OHIP, Subrogation Branch	August 3 & 4, 1978
Gerald Gold	Director, Professional Services Monitoring Branch, OHIP	November 17, 1978
William Lees Gold	Claims Manager, Reliance Insurance Company	October 12, 1978

WITNESS	OCCUPATION	DATE
Dunlop Goodchild	Senior Claims Manager, The Co- operators (formerly, Co-operators Insurance Association (Guelph), or CIAG)	May 17, 1978
Edward Douglas Gooderham	W. A. King and Company Limited	September 21, 1978
Charles Alexander Gordon	OHIP, Subrogation Branch	September 21, 22, 25, 26 & 27 & December 7, 1978
J. Ernest Gordon	OHIP, Peterborough	November 1, 1978
Nuria Graells	IV Team, Haematology, Toronto East General and Orthopaedic Hospital	January 29, 1979
Harold Hopkins Graham	Commissioner, OPP	June 1, 1978
Samuel John Graham	Citizen	January 30, 1979
Catherine Greenwood	Teachers' Payroll Department, Windsor Separate School Board	August 18, 1978
Douglas Charles Grigg	Senior Examiner, The Citadel General Assurance Company (formerly, CNA Assurance Company)	May 17, 1978
Teunis Haalboom	Chief Executive Officer, The Co- operators (formerly, Co-operators Insur- ance Association (Guelph), or CIAG)	May 17, 1978
Winnifred Haines	Manager, Security Department, Bell Canada	May 8, 1978

WITNESS	OCCUPATION	DATE
Dr. Trevor Gerald Hancock	Physician, Lakeshore Area Multi-Services Project (LAMP), Toronto	January 22, 1979
James Frederick Harman	Citizen	January 22, 1979
Maria Assunta Harman	Citizen	January 22, 1979
John R. Harnett	Formerly, Director, Enrolment Branch, OHIP	November 14, 1978
Terrence Steven Harnett	OHIP, London	October 19, 1978
David E. Harry	Director, Management Systems Branch (formerly, Systems Management and Co-ordination Branch, or SMAC), Ministry of Health	January 18, 1979
Dr. Gerald Hart	Director, Department of Haematology, Toronto East General and Orthopaedic Hospital	January 29, 1979
Donald Harold Heaton	Superintendent, RCMP	June 8 & 9 & November 24, 1978
Dr. H. William Henderson	Deputy Registrar, The College of Physicians and Surgeons of Ontario; formerly, Assistant Deputy Minister, Research Development and Information Services, Ministry of Health	February 12, 1979

WITNESS	OCCUPATION	DATE
Jon Hewson	Computer Technician, formerly with Mohawk Data Sciences - Canada Limited (MDS)	March 6, 1979
Herbert Hickling	Assistant Vice- President, Claims, Allstate Insurance Company	June 6, 1978
Joyce Hoad	Senior Clerk, OHIP, St. Catharines	October 20, 1978
Robert Hogarth	Windsor Adjusting Company Limited	August 15, 1978
Frederick Hood	Chairman, Board of Directors, Lawrence Heights Medical Centre, Toronto	January 23, 1979
Ian Hood	Research Analyst	January 23, 1979
Gordon Brian Howe	Sergeant, Fraud Squad, Hamilton- Wentworth Regional Police Department	November 15, 1978
Robert David Humfrey	Peat, Marwick and Partners	October 16 & 17, 1978
Dr. Paul Hunphries	Senior Medical Consultant and Acting Director, Institutional Programme Support Services, Ministry of Correctional Services	March 8, 1979
Dr. Monique Isler	Physician, Lakeshore Area Multi-Services Project (LAMP), Toronto	February 6, 1979

WITNESS	OCCUPATION	DATE
Nour Issa	Receptionist, North York Branson Hospital	August 1, 1978
James Daniel Jack	Group Leader, Eligibility Section, OHIP, London	October 19, 1978
Tony Jennings	Director, Administrative Services, Civil Service Commission	March 13, 1979
Thomas George Johnson	Formerly with Metropolitan Toronto Police	November 21, 1978
Brian George Johnston	Claims Manager, Aetna Casualty Company of Canada	July 24, 1978
George Jolie	Jolie & Todd Investigations	August 14, 15, 16, 17 & 18, 1978
Timothy Martin A. Jones	Private Investiga- tor, formerly with Ron Arnold and Associates Incorporated	May 23, 1978
William Frederick Joyce	Corporal, OPP	May 31, 1978
Dr. Arthur William Karr	Senior Physician, Ford Motor Company of Canada Limited	December 8, 1978
Joan Kerns	Registered Nurse, Queen Street Mental Health Centre, Toronto	March 5, 1979
Louis S. Kerwyn	Manager, Enrolment Inquiry and Standards, OHIP	November 6, 1978

WITNESS	OCCUPATION	DATE
Dr. Roch S. Khazen	Principal Program Advisory, Family Health, Ministry of Health	March 12, 1979
Bryan Moore King	Fraud Squad, Metropolitan Toronto Police	November 21, 1978
Peter Roger King	Special Constable, RCMP	November 27, 1978
Thomas Albert Kingsborough	Director, Environmental Services, The Wellesley Hospital, Toronto	June 15, 1978
Margaret Anne Knight	Enrolment Clerk, OHIP, London	October 19, 1978
Richard Clarence Kruger	Chief X-Ray Technologist, North York Branson Hospital	May 1, 1978
Pauline Kuprenas	Secretary to Director, OHIP, London	October 19, 1978
Kenneth Wayne Laidlaw	Cortlaw Services Limited	June 28 & 29, 1978
Jean Lance	Community Worker, Lawrence Heights Medical Centre, Toronto	February 5, 1979
Lawrence Lander	Lander-Spiers Insurance Adjusters Limited	April 20, 21 & 24, 1978
Philip Keith Latimer	Claims Supervisor, OHIP, Oshawa	October 20, 1978
Bernard Laurin	District Director, OHIP, Sudbury	November 1, 1978

WITNESS	OCCUPATION	DATE
Leslie Lawlor	Chairman, Health Services Committee, Lakeshore Area Multi-Services Project (LAMP), Toronto	February 6, 1979
Ron H. LeBlanc	Co-ordinator, French Language Services, Ministry of Health	November 1, 1978
Arthur Leja	Manager, Ward PH56 (Psycho-Geriatric Unit), Queen Street Mental Health Centre, Toronto	March 5, 1979
Viola Lemon	Director, Medical Records, North York Branson Hospital	August 1, 1978
Mitchell Lennox	The Board of Education for the City of Toronto	March 7, 1978
Joseph P. Leonard	Executive Director, Board of Trustees, Lakeshore Area Multi-Services Project (LAMP), Toronto	February 6, 1979
Dr. Steven Levenson	Physician, Lawrence Heights Medical Centre, Toronto	January 22, 1979
James David Lillie	Private Investigator, formerly with Ron Arnold and Associates Incorporated	May 24, 1978
Dr. Wayne T. R. Linton	Director, Venereal Diseases Clinic, St. Michael's Hospital, Toronto	March 5, 1979

WITNESS	OCCUPATION	DATE
Ernest Albert Lockwood	Employee of Imperial Optical Company Limited	June 14, 1978
William R. Loebach	Manager, Compensation and Benefits, Chrysler Canada Limited	August 21, 1978
Paul Edmund Lowrey	Immigration Officer, Canada Employment and Immigration Commission	October 18, 1978
Robert John Lysak	Constable, Thunder Bay Police Force	January 18, 1979
Lorraine Marie MacDonald	Medical Records Librarian, Metropolitan General Hospital, Windsor	August 22, 1978
Ronald MacDonald	Regional Claims Manager, Federal Insurance Company	May 17, 1978
Allen Inglis MacFarlane	A. I. MacFarlane and Associates Limited	May 16, 1978
Henry MacKillop	Director, Data Development and Evaluation (DD&E), Ministry of Health	January 18, 1979
Donald MacLean	Director, OHIP, Metropolitan Toronto Police	November 6 & 7, 1978
Peter MacNeil	Corporal, RCMP	November 27, 1978
Manu Malkani	Assistant Administrator, Medical Services, The Wellesley Hospital, Toronto	June 14, 1978

WITNESS	OCCUPATION	DATE
Philip Vasil Mangoff	Insurance Investigator, Canadian Claims Research Association (C.C.R.)	September 13, 1978
Roman Edward Mann	Executive Director, Hotel Dieu of St. Joseph Hospital, Windsor	August 21, 1978
Diane Manual	Director, Medical Records, Scarborough General Hospital	November 30, 1978
Angela Maounis	Clerk, Medical Records Department, The Wellesley Hospital, Toronto	June 14, 1978
Kenneth George Maslen	Private Investigator	September 28, 1978
John Maynard	Formerly, Director, Psychiatric Hospitals Branch, Ministry of Health	February 12, 1979
James Clifford McAfrey	Supervisor, Labour Relations, General Motors of Canada Limited	December 8, 1978
James Scott McBride	Staff Superintendent, OPP	February 1, 1979
John McCammon	Administrative Assistant to the Superintendent of Board Services, The Board of Education for the City of North York	March 7, 1979
Bernard McCarthy	Administrator, Scarborough General Hospital	November 30, 1978

WITNESS	OCCUPATION	DATE
Kieran Patrick McCarthy	Private Investi- gator, Quest Investigation Limited (formerly, Director of Operations, Centurion Investigation Limited)	May 25, 30 & 31, 1978
James Edward McCormack	Corporal, OPP	May 31, 1978
Paul Andrew McCourt	Equifax Services Limited (formerly, Retail Credit Company of Canada Limited)	July 31, 1978
James Lance McGarry	Centurion Investigation Limited	May 9 & 10, 1978
Eva Marie McGee	Hospital Eligibility Testing Unit, OHIP, Toronto	October 30, 1978
Alma McGuire	Administrative Clerk, Enrolment Section, OHIP	November 6, 1978
William Raymond Francis McKay	Manager, Toronto Office, Equifax Services Limited (formerly, Retail Credit Company of Canada Limited)	July 24, 25 & 26, 1978
James Alexander McLennan	Claims Manager, OHIP, London	October 19, 1978
Samuel Brian McNabney	Regional Claims Manager, The Hartford Insurance Group	May 17, 1978
John McQueen	Corporal, RCMP	November 27, 1978

WITNESS	OCCUPATION	DATE
William McRae	Director of Toronto East General and Orthopaedic Hospital	August 18, 1978
Dr. John David Medhurst	Medical Director, Toronto East General and Orthopaedic Hospital	January 30, 1979
Dr. Pran Mehta	Orthopaedic Surgeon	June 30, 1978
Ruth Mendelsohn	Registered Nurse; Employee of Centurion Investi- gation Limited	May 10 & 11, 1978
Charles Albert Meredith	Private Investiga- tor, formerly with Ron Arnold and Associates Incorporated	May 24, 1978
Dr. Vernon R. Messer	Physician, Windsor Industrial Clinic	August 22, 1978
Patricia Michaud	Clerk, Sick Leave, Windsor Separate School Board	August 18, 1978
William Kenneth Miller	President, William K. Miller Insurance Adjusters Incorporated	May 24 & 25, 1978
Mabel Mills	Director, Medical Records, St. Joseph's Hospital, London	June 30, 1978
Dr. Patrick John Milner	Physician	June 30, 1978
Linda Montague	Formerly, Record Technician, St. Catharines General Hospital	May 8, 1978

WITNESS	OCCUPATION	DATE
Gene Raymond Young Montgomery	Corporal, RCMP	November 27, 1978
Peter Moon	Reporter, The Globe and Mail	May 25, 1978
George Morgan	Assistant Executive Director, Pro- fessional Services, St. Joseph's Hospital, Toronto	December 4, 1978
Dr. George W. O. Moss	Medical Officer of Health, City of Toronto	March 7, 1979
Susan Du Moulin	Service Co-ordinator, Lakeshore Area Multi-Services Project (LAMP), Toronto	February 6, 1979
Rose Alice Murray	OHIP, London	October 30, 1978
Gerald Raymond Narroway	Private Investigator, Whitehall Bureau of Investigation and Security Incorporated	January 23, 1979
Daniel L. Nearing	Supervisor, Group Enrolment, OHIP	November 6, 1978
John Grant Nearingburg	Vice-President, Claims, Gore Mutual Insurance Company	May 17, 1978
James Nicol	Administrator, The Wellesley Hospital, Toronto	November 30, 1978
James Noble	Deputy Chief, Staff Operations, Metropolitan Toronto Police	November 21, 1978

WITNESS	OCCUPATION	DATE
Dr. Peter J. O'Hara	Medical Director, Scarborough General Hospital	November 30, 1978
Dr. William O'Hara	Director, Employee Health Services Branch, Ministry of Health	March 13, 1979
Frank Joseph Oliva	Private Investigator, Canadian Claims Research Association (C.C.R.)	September 15, 1978
John Herbert Oliver	Chateau Insurance Company	August 2, 1978
Ann Camille Osborne	Medical Records Librarian, Windsor Western Hospital Centre, Inc.	August 22, 1978
Roald Oss	Director, Human Resources Branch, Ministry of Health	March 13, 1979
Albert George Oxlade	Griffin Investigation Agency	June 6, 1978
Paul Martin Palango	Reporter, The Globe and Mail	December 5, 1978
Jayan Panikkar	Claims Manager, Security Mutual Casualty Company	June 1, 1978
Dorothy May Pankhurst	Eaton/Bay Insurance Company	May 16, 1978
Ernest S. Pare	Formerly of OHIP, Windsor	November 1, 1978
Bruce Murray Parsonson	Chief Examiner, Ontario Branch, Canadian General Insurance Company	May 17, 1978

WITNESS	OCCUPATION	DATE
George Anthony Pattison	Workmen's Compensation Officer, City of Windsor	August 21, 1978
Louis Jack Pelissero	Inspector, OPP	April 20, May 8, 9 & 10, September 27, 1978
Victoria Onge Percival	Counsel, Commission d'enquête sur des opérations policières en territoire québécois (Keable Commission)	December 5, 1978
Ralph L. Persad	Senior Consultant, Venereal Disease Section, Ministry of Health	February 8, 1979
Stephanie Ann Phillips	Investigator, Canadian Claims Research Association (C.C.R.)	September 15, 1978
John Pinkerton	Insurance Adjuster	April 24, 1978
William Bruce Pogue	Executive Director, Woodstock General Hospital	June 29, 1978
Victoria Polischuk	Medical Records Librarian, Lakehead Psychiatric Hospital, Thunder Bay	January 18, 1979
Dr. John Porter	Physician	April 25, 26 & 27 & May 1, 1978
Terry Adam Power	Investigator, Canadian Claims Research Association (C.C.R.)	September 14 & 15, 1978
Carol Presement	Investigator, Franco Investigation Services	June 2, 1978

WITNESS	OCCUPATION	DATE
Peter Radley	Director of Manufacturing, Dare Foods Limited	December 8, 1978
Michael Joseph Rafferty	Enforcement Program Specialist, Regional Office, Canada Employment and Immigration Commission	November 16, 1978
Christina Ratzburg	Claims Manager, OHIP, Sudbury	November 1, 1978
Gary Reid	Citizen	January 16, 1979
Sydney Renton	Administrator, York-Finch General Hospital, Toronto	August 1, 1978
Harry Charles Ribble	Security Super- visor, Centurion Investigation Limited	June 1, 1978
John Harry Riddell	League for Socialist Action	March 9, 1979
Mrs. John Riddell	Citizen	March 27, 1979
Robert Allan Preston Rideout	Manager, Union Relations, Ford Motor Company of Canada Limited	August 21, 1978
Ronald James Rigglesworth	Investigator, Dominion Stores	May 31, 1978
Ronald Brian Roberts	Detective Sergeant, OPP	November 21, 1978
James Emerson Robinson	Executive Director, North York General Hospital	August 2, 1978

WITNESS	OCCUPATION	DATE
James Barry Studley Rose	Assistant Deputy Minister, Administration and Health Insurance, Ministry of Health	November 23, 1978
Allan Ross	Systems Specialist, Management Systems Branch (formerly, Systems Management and Co-ordination Branch, or SMAC), Ministry of Health	February 18 & March 6, 1979
Donald W. Ross	Vice-President, Claims, Markel Service Canada Limited	May 23, 1978
Dr. John Gordon Ross	Vice-President of Medical Director, Mutual Life Assurance Company of Canada	March 6, 1979
Joan Ryza	Chief Medical Record Librarian, North York General Hospital	August 2, 1978
Susan Jane Quin	Secretary, Whitehall Bureau of Investigation and Security Incorporated	January 23, 1979
Ahsan Sadiq	Manager, Claims Services, OHIP	November 15, 1978
Kenneth Mitchell St. Clair	Staff Sergeant, RCMP	September 28, 1978
Ron Sandelli	Sergeant, Metropolitan Toronto Police	September 28, 1978

WITNESS	OCCUPATION	DATE
John Andrew Sarjeant	Executive Director, Information Systems, Ministry of Health	January 18, 1979
Dr. Joseph Schisler	Physician, Chrysler Canada Limited	August 21, 1978
Frank Paul Sebo	Education Officer, Ministry of Education	March 12, 1979
William Fletcher Seaman	Bennett and Seaman Insurance Adjusters Incorporated	June 2, 1978
Nancy Shannon	Insurance Adjuster, A. I. MacFarlane and Associates Limited	May 15, 1978
Lee D. Shirk	Claims Manager, The Paul Revere Life Insurance Company	July 24, 1978
Dr. Morton Shulman	Physician; Columnist, The Toronto Sun	January 30, 1979
Dr. Joanne Silcox	Psychiatrist	February 12, 1979
Jon R. Skafel	Executive Director, St. Thomas-Elgin General Hospital	June 30, 1978 & February 7, 1979
Eva Marie Skorokhid	Telephone Inquiry Clerk, OHIP	November 6, 1978
Norman Smith	Manager, Commercial Claims, The Prudential Assurance Company Limited	July 24, 1978
Peter Smith	Chief Agent, Federal Insurance Company	May 17, 1978

WITNESS	OCCUPATION	DATE
Vivian Smith	Registered Nurse; PMI Data Maintenance Limited	August 2, 1978
James Stanley Spencer	Executive Director, Tillsonburg District Memorial Hospital	June 29, 1978
Michael Spiers	Lander-Spiers Insurance Adjusters Limited	April 24, 1978
M. J. Spooner	Chief Superintendent, RCMP	June 9 & November 24 & 27, 1978
Arnold G. Stapleton	Director of Personnel, General Motors of Canada Limited	January 15, 1979
John Steele	Member, Revolutionary Workers League	March 28, 1979
Carol Stein	Patients' Accounts, North York General Hospital	August 2, 1978
Jack Harold Stein	Pharmacist, Ottawa Pharmacy Limited	August 18, 1978
R. Alex Stephens	Director, Medical Services, St. Joseph's Hospital, London	June 30, 1978
Wilbert G. Stephens	Purchasing Agent, Windsor Separate School Board	August 22, 1978
Douglass Roy Stewart	Vice-President, Central Region, Equifax Services Limited (formerly, Retail Credit Company of Canada Limited)	July 31 & August 1, 1978

WITNESS	OCCUPATION	DATE
Wayne John Stewart	Private Investigator, Centurion Investigation Limited	May 11 and 23 & September 28, 1978
Charles Richard Stickley	Private Investigator, Jolie & Todd Investigations	August 15, 16 & 17, 1978
Dr. Gary Stoik	Surgeon, Toronto East General and Orthopaedic Hospital	January 29, 1979
Melvin Roy Stroud	Detective Sergeant, OPP	November 21, 1978
Merlin Stroud	Staff Sergeant and Deputy Registrar of Private Investigators and Security Guards, OPP	May 31, 1978
Doreen Honor Stuart	Personnel Manager, Dare Foods Limited	December 8, 1978
Harvey F. Sullivan	Vice-President, Medical Services, Victoria Hospital, London	June 30, 1978
Samuel Isaac Sussman	Director, Social Work, London Psychiatric Hospital	February 12, 1979
William B. Swarts, III	Lawyer, Medical Information Bureau Incorporated (MIB)	March 6, 1979
Geoffrey Taylor	W. A. King and Company Limited	September 21, 1978
Ian William Taylor	Superintendent, RCMP	March 9 & 27, 1978

WITNESS	OCCUPATION	DATE
Clifford Kenneth Temple	Administrator, Lakehead Psychiatric Hospital, Thunder Bay	January 18, 1979
Dr. Bruce W. Thomas	Medical Director, Special Treatment Clinic, Women's College Hospital, Toronto	February 8, 1979
Colin M. Thomas	Thomas, Williams and Rowell Insurance Adjusters Limited	June 29, 1978
Ivy Thomson	Administrative Assistant, Enrolment Section, OHIP	November 6, 1978
George Alvin Thornton	Executive Director, The Wellesley Hospital, Toronto	June 15, 1978
Joan Barbara Todd	Registered Nurse, Metropolitan General Hospital, Windsor	August 18, 1978
John F. Todd	Jolie & Todd Investigations	August 14, 15 & 16 & December 8, 1978
Anna Marie Tolgyes	Medical Records Librarian, St. Thomas-Elgin General Hospital	February 7, 1979
James Villemaire	Acting Superintendent, OPP	June 1, 1978
Joan Voll	Industrial Health Nurse, Dare Foods Limited	December 7, 1978

WITNESS	OCCUPATION	DATE
Suzanne Vorvis	Co-ordinator, Medical Records, University Hospital, London	June 30, 1978
Gordon Voutt	Assistant General Manager, The Hartford Insurance Group	May 17, 1978
Jack R. Walden	Manager, Pay Direct Administration, OHIP	November 6, 1978
Sharon Walker	Plant Nurse, Dare Foods Limited	January 8, 1979
John Norbert Walsh	President, Canadian Automobile Service Association Limited	July 24, 1978
Kenroy Alfred Wedderburn	Unit Supervisor and Investigator, Equifax Services Limited (formerly, Retail Credit Company of Canada Limited)	July 31, 1978
Morley David Welch	Director of Personnel, Transmission Plant, General Motors of Canada Limited	December 8, 1978
Elizabeth Kathleen Wey	Registered Nurse, General Motors of Canada Limited, Scarborough	January 15, 1979
Albert Joseph White	Private Investigator, Canadian Claims Research Association (C.C.R.)	September 6, 7, 13, 14 & 21, 1978

WITNESS	OCCUPATION	DATE
Robert White	Staff Sergeant, OPP	May 31, 1978
Rev. Barry Percival Whittaker	Director, St. Thomas-Elgin General Hospital	February 7, 1979
Eric R. Willcocks	Executive Director, Toronto East General and Orthopaedic Hospital	January 29, 1979
Donald Keith Wilson	Superintendent, RCMP	December 5, 1978
Dr. Lynn Robert Sutherland Wilson	Plant Physician, Dare Foods Limited	December 7, 1978
Thomas Wise	Superintendent, Lawrence Heights Medical Centre, Toronto	February 5, 1979
Ralston Wong	Manager, Systems Management, Manage- ment Systems Branch (formerly, Systems Management and Co-ordination Branch, or SMAC), Ministry of Health	January 17, 1979
William Barco Wordingham	Claims Manager, OHIP, Toronto	November 7 & 14, 1978
Charles Clarke Wright	President, W. A. King and Company Limited	September 21, 1978
Jane Wright	Secretary to Dr. Wright	July 26, 1978
Robert Wright	Employment Co-ordinator, Chrysler Canada Limited	August 18, 1978

WITNESS	OCCUPATION	DATE
Dr. Damiana Wrobel	Medical Director, Toronto Blood Transfusion Service, Canadian Red Cross	January 31, 1979
Doreen Yates	Secretary and Receptionist, Physiotherapy Depart- ment, York-Finch General Hospital, Toronto	August 1, 1978
Robert John Leonard Young	Inspector of Detectives, London Police Force	October 18, 1978
Steven Young	Abstainers' Insurance Company	July 24, 1978
Blanca Zahoransky	Formerly, Blood Bank Technologist, Toronto East General and Orthopaedic Hospital	January 29, 1979
Zoltan Zahoransky	Formerly, Employee of Toronto East General and Orthopaedic Hospital	January 31, 1979

Policy Hearings

ORGANIZATION/ SUBMITTOR	REPRESENTATIVE/ TITLE	DATE
The Association of Investigators and Guard Agencies of Ontario	Lionel Dallas	June 14, 1979
Association of Nursing Directors and Supervisors of Ontario Official Health Agencies (ANDSOOHA)	Jane Keslick, Past President Florence Bonyun	May 28, 1979
W. Alan Backley	Deputy Provincial Secretary, Provincial Secretariat for Social Development (formerly, Deputy Minister of Health)	June 18, 1978
Blind Organization of Ontario with Self-Help Tactics (BOOST)	John Rae, President Ann Musgrave	May 24, 1979
The Board of Education for the City of Toronto	John Bull, Counsel Brian Garvo, Assistant Counsel M. Lennox, Superintendent of Professional Services Dr. Ted Brown, Co-ordinator of Student Services	May 14, 1979

ORGANIZATION/ SUBMITTOR	REPRESENTATIVE/ TITLE	DATE
	Allen Price, Executive Assistant to the Director of Education	
	Margaret Deeth, Co-ordinator of Early Childhood Education	
	Sheila Meagher, Trustee	
Clifford Brown	Individual	May 3, 1979
Canadian Council on Hospital Accreditation	Arnold L. Swanson, Executive Director	May 18, 1979
Canadian Health Record Association (CHRA)	Janet Milner, Executive Director	May 30, 1979
	Vicki Tichbourne, President	
	Sister McCloskey	
	Janet Arnott	
	Jim Finch, Counsel	
Canadian Mental Health Association, Ontario Division (Mental Health/ Ontario)	Dr. George Souter, Vice-President and Chairman, Legislative Advocacy Committee	May 30, 1979
	Mr. David Baker	

ORGANIZATION/ SUBMITTOR	REPRESENTATIVE/ TITLE	DATE
Canadian Organization for Advancement of Computers in Health (COACH)	Denis Protti, President Judy Moran	June 19, 1979
Citizen's Commission on Human Rights	Barry Hobbs Lorne Alter Alice Whalen Margaret Coxson	June 29, 1979
Civil Liberties Association	Mary Eberts, Professor Walter Tarnopolsky, Professor J. S. Midanik Alan Borovoy	June 11, 1979
College of Nurses of Ontario	Joan MacDonald, Director Elizabeth Stewart, Counsel	June 13, 1979
The College of Physicians and Surgeons of Ontario	Dr. James F. Ballantyne, Meryl Walker, Lay Member of Council Dr. J. Fay, Chairman, Complaints Committee	May 25, 1979

ORGANIZATION/ SUBMITTOR	REPRESENTATIVE/ TITLE	DATE
	Dr. Ronald M. Jackson, Complaints Officer	
	Dr. William F. Wales, Officer in Charge, Complaints Department	
	Dr. Gary Gibson	
	Dr. H. William Henderson, Acting Deputy Registrar	
H. Dominic Covvey	Toronto General Hospital, Cardiovascular Unit	May 16, 1979
Dr. Alan S. Davidson	Individual	June 12, 1979
Disabled Workers of Ontario	Tom White Ross Edwards	May 24, 1979
Ross Dowson	Individual H. Kopyto, Counsel for R. Dowson	June 14, 1979
Green Shield Prepaid Services (formerly, Prescription Services Incorporated)	W. A. Wilkinson, Chairman Walter Austen, President and Chief Executive Officer Fred Thibeault, Vice-President of Benefits and Claims; Pharmaceutical Director	May 16, 1979

ORGANIZATION/ SUBMITTOR	REPRESENTATIVE/ TITLE	DATE
	R. Walker, Counsel	
Cyril Greenland	Professor, McMaster University, School of Social Work	May 16, 1979
The Health Disciplines Board	Edward A. Pickering, Chairman	June 12, 1979
	Ronald Watson, Vice-Chairman	
	Donald McKay	
	Stanley V. Green	
	Barbara Nichols	
	R. M. Fraser, Counsel	
Industrial Accident Victims Group of Ontario (IAVGO)	William D. Griffith, Office Manager/ Vice-President	May 2, 1979
	George Lavorato	
International Business Machines Canada Limited (IBM)	Grant Murray, Vice-President, General Counsel and Secretary	May 17, 1979
	Bob Logan, Director of External Program	
	Bob Zuckerman, Co-ordinator, Marketing Manager, Industrial Health Services	

ORGANIZATION/ SUBMITTOR	REPRESENTATIVE/ TITLE	DATE
	Dave Milne, Marketing Manager, Data Processing Division	
The Lieutenant Governor's Advisory Review Board	Barry Swadron, Counsel	May 23, 1979
Angus Lockwood	Individual	May 14, 1979
London Police Force	Harold McBride, Superintendent	May 9, 1979
	Don Andrews, Inspector	
Kieran Patrick McCarthy	Private Investigator, Quest Investigation Limited (formerly, Director of Opera- tions, Centurion Investigation Limited)	May 9, 1979
McMaster University	Dr. J. Fraser Mustard, Dean, Faculty of Health Services	June 28, 1979
	Dr. K. Ahmed, Software Supervisor, Computation Services Unit	
	Dr. Gary D. Anderson, Associate Professor, Clinical Epidemiology and Biostatistics	

ORGANIZATION/
SUBMITTOR

REPRESENTATIVE/
TITLE

DATE

Dr. John M. Cleghorn,
Professor and
Chairman, Psychiatry

M. Gent, Professor
and Chairman,
Clinical Epidemiology
and Biostatistics

Robin S. Roberts,
Associate Professor,
Clinical Epidemiology
and Biostatistics

Dr. David L. Sackett,
Professor, Clinical
Epidemiology and
Biostatistics

Dr. N. Spinner,
Professor, Psychiatry

Dr. D. L. Streiner,
Professor, Psychiatry

Dr. William J. Walsh,
Professor, Medicine

R. C. Walker,
Executive Vice-
President, Chedoke-
McMaster Hospital

Dr. Kenneth C.
Charron, Professor,
Clinical Epidemiology
and Biostatistics

Dr. R. Davidson,
Department of
Genetics

Dr. A. Gardner,
Department of
Genetics

ORGANIZATION/ SUBMITTOR	REPRESENTATIVE/ TITLE	DATE
	Dr. I. Uchida, Department of Genetics	
	Dr. Carr, Department of Genetics	
	Dr. L. Bandler, Department of Genetics	
Metropolitan Separate School Board (MSSB)	H. M. Kelly, Counsel Teresa Ravanello, Chief Social Worker Dr. Paul O'Grady, Chief Psychologist	June 18, 1979
Metropolitan Toronto Police	Deputy Chief James Noble Cullen Johnson, Constable Peter Swain, Sergeant	June 11 & 20, 1979 June 20, 1979
National Cancer Institute of Canada (NCIC)	Dr. A. B. Miller, Director of Epidemiology Celia E. Corcoran, Counsel	May 15, 1979
City of North York, Department of Public Health	Dr. Joan McCausland, Associate Medical Officer of Health	May 14, 1979

ORGANIZATION/ SUBMITTOR	REPRESENTATIVE/ TITLE	DATE
	Eva Wilson, Acting Director of Public Health Nursing	
	Dan Persaud, Quarantine Inspector	
Office of the Chief Coroner for Ontario	Dr. Ross C. Bennett, Deputy Chief Coroner for Ontario	May 18, 1979
Ontario Association for the Mentally Retarded (OAMR)	James Montgomerie, Vice-President	June 7, 1979
	David Baker	
Ontario Association of Pathologists	Dr. Hugh Van Patter, President	May 18, 1979
	Dr. Hans Sepp, Chairman, Forensic Subcommittee	
The Ontario Board of Examiners in Psychology	Dr. Barbara Wand, Director	May 29, 1979
The Ontario Cancer Treatment and Research Foundation (OCTRF)	Dr. J. William Meakin, Executive Director	May 15, 1979
	Dr. E. Aileen Clarke, Head of Epidemiology and Statistics	
	Dr. A. H. Seller, Medical Statistician	

ORGANIZATION/ SUBMITTOR	REPRESENTATIVE/ TITLE	DATE
	Dr. R. Spengeler, Assistant Head of Epidemiology	
	Dr. C. R. Howe, Senior Statistician	
Ontario Civil Service Commission (CSC)	Elizabeth Aboud Tony Jennings	May 3, 1979
Ontario College of Pharmacists	W. R. Foltas, President A. J. Dunsdun, Deputy Registrar W. R. Wesley, Registrar P. D. Isbister, Counsel	May 29, 1979
Ontario Health Record Association	Pauline Baldwin, President Jean Base Janet Arnott Frances Emerson J. Fleming, Counsel Marion Ogilvy Sister McCloskey Vicki Tichbourne	May 30 & June 14, 1979 May 30, 1979 June 14, 1979

ORGANIZATION/ SUBMITTOR	REPRESENTATIVE/ TITLE	DATE
Ontario Hospital Association (OHA)	John W. Wevers, President	May 18, 1979
	Roger A. Slute, Executive Director, Association Services	
	Rodney G. Walsh, Director, Legislation Services	
	Dr. James D. Galloway, Past President	
	R. Alan Hay, Executive Director	
	Judith A. Moran, Consultant, Health Records and Careers	
Ontario Medical Association (OMA)	Dr. Douglas Y. Caldwell, President	May 25 & June 6, 1979
	Dr. Ernest Mastromatteo, Chairman, Section on Occupational Health	
	Dr. Jack Saunders, Director, Health Services	
	Dr. Jerry J. I. Cooper, Section on Psychiatry	May 25, 1979
Ontario Ministry of Health	Dr. J. B. Armstrong, Senior Medical Consultant, Epidemiology	May 15, 1979

ORGANIZATION/ SUBMITTOR	REPRESENTATIVE/ TITLE	DATE
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Thomas Campbell,
Deputy Minister

July 4, 1979

John Andrew
Sarjeant, Executive
Director, Infor-
mation Systems
Division

Gordon Ellis
Fetherston, General
Manager, Health
Insurance Division

Dr. Barbara J.
Blake, Director,
Public Health Branch

Dr. Allan E. Dyer,
Assistant Deputy
Minister,
Institutional Health
Services

Dr. Roch S. Khazen,
Chief, Family
Planning Unit,
Program Advisory
Branch

Dr. G. Gold,
Director, Program
Advisory Branch

Dr. Gordon K.
Martin,
Executive Director,
Health Programs
Division

Dr. R. Andreychuk,
Medical Consultant,
Communicable Disease
Control, Program
Advisory Branch

ORGANIZATION/ SUBMITTOR	REPRESENTATIVE/ TITLE	DATE
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Dr. Ralph L. Persad,
Senior Medical
Consultant, Venereal
Disease, Program
Advisory Branch

A. Burrows,
Acting Executive
Co-ordinator, Drug
Benefits Branch

D. Buchanan,
Director, Insurance
Claims Branch

David Bernstein,
Director, Legal
Branch

D. Harry, Director,
Management Systems
Branch (formerly,
Systems Management
and Co-ordination
Branch, or SMAC)

S. Badham,
Legal Branch

Dr. William J.
Copeman,
Medical Officer of
Health, Northern
Ontario Public
Health Services

J. B. Ackland,
Area Planning
co-ordinator
(Northern Area)

ORGANIZATION/ SUBMITTOR	REPRESENTATIVE/ TITLE	DATE
	W. O'Neill, Senior Administrative Consultant, Institutional Operations Branch	
Ontario Ministry of Labour, Occupational Health and Safety Division	Dr. C. Rodney May, Assistant Deputy Minister Paul Hess, Legal Services Branch Ian Szlazak, Legal Services Branch Dr. P. Pelmear, Head of Medical Services Dr. Ann Robinson, Head of Analytical Services Dr. Gary DeBow	June 13, 1979
Ontario Occupational Health Nurses Association (OOHNA)	S. A. Arnold D. Schwab G. Blackwell S. Matchett M. Fischer M. Wenman	April 30, 1979
Ontario Psychological Association	Dr. Barry Francis, President	May 29, 1979

ORGANIZATION/ SUBMITTOR	REPRESENTATIVE/ TITLE	DATE
	Dr. Xavier Plaus, President Elect	
Ontario Public Service Employees Union (OPSEU)	Ivor Oram	May 3, 1979
Patients' Rights Association	Anne Coy Harry Beatty David Coburn	May 24, 1979
Registered Nurses' Association of Ontario (RNAO)	Maureen Powers Isabel Brown Jocelyn Hezekiah	May 28, 1979
Royal Canadian Mounted Police (RCMP)	Arthur C. Pennington, Counsel Donald Harold Heaton, Superintendent M. J. Spooner, Chief Superintendent	June 21, 1979
Statistics Canada	Dr. Joseph Hauser, Director, Health Division	May 10, 1979
Dr. Marvin Tile	Chief of Orthopaedics, Sunnybrook Hospital	May 15, 1979

ORGANIZATION/ SUBMITTOR	REPRESENTATIVE/ TITLE	DATE
City of Toronto, Department of Health	Dr. George W. O. Moss, Medical Officer of Health	May 14, 1979
	Mary Willett, Nursing Division	
	Jean Erb, Medical Services	
	Dr. James Mitchell, Deputy Medical Officer of Health	
	H. Pastuszak, Counsel for the City of Toronto	
University of Toronto, Department of Psychiatry, Ad Hoc Committee	Dr. F. A. S. Jensen, Metropolitan Toronto Forensic Service (Metfors)	May 8, 1979
	Dr. B. A. Martin, Staff Psychiatrist, Clarke Institute of Psychiatry	
United Automobile Workers of America, Local 222 (UAW)	Jack Vaillancourt, 1st Vice-President and Insurance Representative	May 2, 1979
Varta Batteries Limited	W. A. Roork, Director, Safety and Health	April 30, 1979
The Workmen's Compensation Board (WCB)	G. W. Reed, Q.C., Vice-Chairman of Appeals	May 1, 1979

ORGANIZATION/
SUBMITTOR

REPRESENTATIVE/
TITLE

DATE

V. G. Sweeney,
Executive Director,
Administrative
Resources Division

Ronald W. Stephens,
Director, Program
Planning and
Statistical Services
Branch

M. Czetyrbok,
Director, Records
Management Branch

W. R. Kerr,
Executive Director,
Claims Services
Division

A. J. Darnbrough,
Director,
Adjudication Branch

Douglas Cain,
Divisional
Co-ordinator, Claims
Services Branch

Dr. W. J. McCracken,
Executive Director,
Medical Services
Division

Douglas Farquharson,
Registrar of Appeals

John Wysocki,
Executive Director,
Rehabilitation
Services Branch

ORGANIZATION/ SUBMITTOR	REPRESENTATIVE/ TITLE	DATE
	John Boyd, Director, Vocational Rehabilitation Branch	
	W. R. Riddell, General Counsel	
York Central Hospital	Dr. Dennis Rankin John Flint James Hepburn Dr. John A. Blakely Dr. Peter G. Morse	June 29, 1979

APPENDIX V

List of Briefs

The Advocates' Society,
Toronto, Ontario.

Aetna Casualty Company of
Canada/ The Excelsior Life
Insurance Company,
Toronto, Ontario.

John B. Armstrong, M.D.,
Toronto, Ontario.

The Association of Genetic
Counsellors of Ontario,
Toronto, Ontario.

The Association of
Investigators and Guard
Agencies of Ontario,
Toronto, Ontario.

Association of Nursing
Directors and Supervisors
of Ontario of Official Health
Agencies,
Toronto, Ontario.

David Gordon Atfield,
London, Ontario.

Atikokan General Hospital,
Atikokan, Ontario.

Ronald G. Atkey,
Toronto, Ontario.

J. Roderick Barr, Q.C.,
St. Catharines, Ontario.

City of Barrie,
Barrie, Ontario.

Biological Photographic
Association, Lake Ontario
Chapter,
Toronto, Ontario.

The Board of Education for the
City of Toronto,
Toronto, Ontario.

Boards of Commissioners of
Police in Ontario:
Amherstburg, Barrie,
Belleville, Brantford,
Brockville, Carleton Place,
Chatham, Cornwall, Deep River,
Durham (town and region),
Essex, Fort Frances, Gananoque,
Gloucester, Goderich, Guelph,
Haldimand-Norfolk, Halton,
Hamilton-Wentworth, Hanover,
Hawkesbury, Innisfil, Kenora,
Kingston, Kingsville, Kirkland
Lake, Leamington, Listowel,
London, Metropolitan Toronto,
Nepean, Niagara, North Bay,
Orangeville, Orillia, Ottawa,
Peel, Pembroke, Peterborough,
Petroliia, Picton, Port Elgin,
Prescott, Sandwich West,
Sarnia, Sault Ste Marie, Smith
Falls, Stratford, Sudbury,
Thunder Bay, Timmins, Vanier,
Wallaceburg, Waterloo, Windsor,
Woodstock, York.

B. A. Boyd, M.D.,
Medical Director,
Mental Health Centre,
Penetanguishene, Ontario.

Chris Bradshaw,
Ottawa, Ontario.

Aidan M. Brady, M.D.,
Tilbury, Ontario.

The Brantford General Hospital,
Brantford, Ontario.

Brotherhood of Locomotive
Engineers,
Division 535,
Kenora, Ontario.

Clifford Brown,
Conn, Ontario.

Canadian Association of
Accident and Sickness Insurers,
Toronto, Ontario.

Canadian Association of
Rehabilitation Personnel,
Toronto, Ontario.

Canadian Chemical Workers
Union,
Local 2,
London, Ontario.

Canadian Civil Liberties
Association,
Toronto, Ontario.

Canadian Health Record
Association,
Oshawa, Ontario.

The Canadian Life Insurance
Association,
Toronto, Ontario.

Canadian Mental Health
Association, Ontario Division,
Toronto, Ontario.

Canadian Organization for
Advancement of Computers in
Health (COACH),
Edmonton, Alberta.

Canadian Textiles Institute,
Montreal, Quebec.

Carleton University,
Health Services,
Ottawa, Ontario.

Cataraqui Professional
Investigations Limited,
Kingston, Ontario.

Chedoke-McMaster Hospital,
Hamilton, Ontario.

The Children's Aid Society
of Ottawa-Carleton,
Ottawa, Ontario.

Children's Hospital of
Eastern Ontario,
Ottawa, Ontario.

Citizen's Commission on
Human Rights,
Toronto, Ontario.

Citizens for Responsible
Education,
Rexdale, Ontario.

Clarke Institute of Psychiatry,
Toronto, Ontario.

College of Nurses of Ontario,
Toronto, Ontario.

College of Optometrists of
Ontario,
Toronto, Ontario.

The College of Physicians and
Surgeons of Ontario,
Toronto, Ontario.

The College of Physicians and
Surgeons of Ontario,
Medical Review Committee,
Toronto, Ontario.

Consumers' Association of
Canada,
Toronto, Ontario.

David Cook,
Toronto, Ontario.

The Co-operators,
Toronto, Ontario.

Cornwall General Hospital,
Board of Governors,
Cornwall, Ontario.

Corporate Foods Limited,
Toronto, Ontario.

H. B. Cotnam, M.D.,
Chief Coroner for Ontario,
Toronto, Ontario.

The County of York Law
Association,
Toronto, Ontario.

H. Dominic Covvey,
Toronto, Ontario.

Alan S. Davidson, M.D.,
Bracebridge, Ontario.

Disabled Workers of Ontario,
Scarborough, Ontario.

Ross Dowson,
Toronto, Ontario.

The Corporation of the Borough
of East York,
Toronto, Ontario.

Borough of East York Health
Unit,
Toronto, Ontario.

The Elizabeth Fry Society,
Ottawa Branch,
Ottawa, Ontario.

Borough of Etobicoke,
Board of Health,
Toronto, Ontario.

Mary Anne Evans,
Board of Governors,
St. Thomas-Elgin Hospital,
Union, Ontario.

Family and Children's
Services of the District of
Kenora,
Kenora, Ontario.

Family Services of
Hamilton-Wentworth,
Hamilton, Ontario.

David S. Faul,
Pickering, Ontario.

David H. Flaherty, Ph.D.,
London, Ontario.

H. Allen Gardner, M.D.,
Toronto, Ontario.

Joanne Glabe,
Hamilton, Ontario.

C. C. Gotlieb,
Head of Cytogenetics,
Toronto General Hospital,
Toronto, Ontario.

Grace Hospital,
Medical Records Department,
Ottawa, Ontario.

Greater Windsor Senior
Citizens Centres Association,
Windsor, Ontario.

Green Shield Prepaid Services
Incorporated,
Windsor, Ontario.

Cyril Greenland,
Hamilton, Ontario.

The Guarantee Company of North
America,
Montreal, Quebec.

Hamilton District Health
Council,
Assessment and Placement
Service,
Hamilton, Ontario.

Hamilton-Wentworth Regional
Health Unit,
Hamilton, Ontario.

T. Hancock,
Toronto, Ontario.

Health and Welfare Canada,
Health Programs Branch,
Ottawa, Ontario.

The Health Disciplines Board,
Toronto, Ontario.

R. Ian Hector, M.D.,
Toronto, Ontario.

The Hospital for Sick Children,
Toronto, Ontario.

Industrial Accident Victims
Group of Ontario,
Toronto, Ontario.

Frank C. Innes,
Windsor, Ontario.

Insurance Bureau of Canada,
Toronto, Ontario.

IBM Canada Limited,
Toronto, Ontario.

Interprofessional Committee on
Child Abuse,
St. Catharines, Ontario.

Richard Isaac, M.D.,
Toronto, Ontario.

I. H. Jennings,
Georgetown, Ontario.

John Howard Society of
Ontario,
Toronto, Ontario.

William Keane, D.D.S.,
Bowmanville, Ontario.

Joel B. Kohn,
Toronto, Ontario.

John Kudelka,
Newmarket, Ontario.

Lakeshore Area
Multi-Services Project Inc.
(LAMP),
Toronto, Ontario.

Lambton District Health
Council,
Sarnia, Ontario.

Jeanne Kirk Laux,
Ottawa, Ontario.

The Law Society of Upper
Canada,
Toronto, Ontario.

Rita M. Leahy,
Toronto, Ontario.

The Lieutenant Governor's
Advisory Review Board,
Toronto, Ontario.

London Police Force,
London, Ontario.

Susan Lyndon,
London, Ontario.

Barbara E. Malcolm,
Toronto, Ontario.

Ronald D. Manes,
Toronto, Ontario.

T. David Marshall,
Cayuga, Ontario.

Charlotte Matthews,
Sarnia, Ontario.

Margaret McLaughlin, Reg. N.,
Toronto, Ontario.

McMaster University,
The Faculty of Health
Sciences,
Hamilton, Ontario.

Gerald McPhee,
Scarborough, Ontario.

Medical Information Bureau,
Incorporated,
Greenwich, Connecticut.

Metropolitan Separate School
Board,
Toronto, Ontario.

Metropolitan Toronto Police,
Planning and Research Bureau,
Toronto, Ontario.

C. G. Millard,
Schumacher, Ontario.

Frances H. Miller, Reg. N.,
Toronto, Ontario.

Patricia Mitchell,
Hamilton, Ontario.

Montfort Hospital,
Medical Records Department,
Ottawa, Ontario.

Bruce E. Morgan, M.D.,
Belleville, Ontario.

Robert W. Morgan, M.D.,
Toronto, Ontario.

T. P. Morley, M.D.,
Toronto, Ontario.

Peter G. Morse, M.D.,
Thornhill, Ontario.

G. R. Musgrove, M.D.,
Windsor, Ontario.

National Cancer Institute of
Canada,
Epidemiology Unit,
Toronto, Ontario.

Niagara Regional Health Unit,
Welland, Ontario.

City of North York,
Board of Health and
Department of Public Health,
Willowdale, Ontario.

Northwestern General
Hospital,
Toronto, Ontario.

Sheila Oliver,
Toronto, Ontario.

Ontario Association for
Children with Learning
Disabilities,
Toronto, Ontario.

The Ontario Association for
the Mentally Retarded,
Toronto, Ontario.

Ontario Association of
Chiefs of Police,
Toronto, Ontario.

Ontario Association of
Children's Aid Societies,
Toronto, Ontario.

Ontario Association of
Pathologists,
Windsor, Ontario.

The Ontario Board of
Examiners in Psychology,
Toronto, Ontario.

The Ontario Cancer Treatment
and Research Foundation,
Toronto, Ontario.

The Ontario Chiropractic
Association,
Toronto, Ontario.

The Ontario Civil Service
Commission,
Toronto, Ontario.

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Record Administrators,
Goderich, Ontario.

Ontario College of Pharmacists,
Toronto, Ontario.

The Ontario Dental
Association,
Toronto, Ontario.

Ontario Federation of Labour,
Toronto, Ontario.

The Ontario Health Record
Association,
Goderich, Ontario.

Ontario Hospital Association,
Toronto, Ontario.

Ontario Medical Association,
Toronto, Ontario.

Ontario Medical Association,
Section on Occupational
Health,
Toronto, Ontario.

Ontario Ministry of Health,
Toronto, Ontario.

Ontario Ministry of Labour,
The Occupational Health and
Safety Division,
Toronto, Ontario.

Ontario Occupational Health
Nurses Association,
Toronto, Ontario.

Ontario Provincial Police,
Toronto, Ontario.

Ontario Psychiatric
Association,
Toronto, Ontario.

Ontario Psychological
Association,
Toronto, Ontario.

Ontario Public Service
Employees Union,
Toronto, Ontario.

Ontario Secondary School
Teachers' Federation,
Toronto, Ontario.

The Ontario Society of Medical
Technologists,
Toronto, Ontario.

Jan Ostrowski,
Huntsville, Ontario.

Ottawa-Carleton Regional
District Health Council,
Ottawa, Ontario.

Ottawa Civil Hospital,
The Board of Trustees,
Ottawa, Ontario.

Ottawa General Hospital,
Medical Record Department,
Ottawa, Ontario.

Ottawa General Hospital,
Social Service Department,
Ottawa, Ontario.

Oxford County Board of Health,
Woodstock, Ontario.

Patients' Rights Association,
Toronto, Ontario.

Fred G. Peet,
Ottawa, Ontario.

Perth County Medical Society,
Stratford, Ontario.

Public Health Nurses'
Interest Group,
Toronto, Ontario.

Gouvernement du Québec,
Ministère des Affaires
sociales
Quebec, P.Q.

P. Gordon Queen,
Woodstock, Ontario.

Queen's University,
Faculty of Medicine,
Kingston, Ontario.

Queensway Carleton Hospital,
Medical Records Department,
Ottawa, Ontario.

Helen K. Rankin,
Sarnia, Ontario.

Red Lake Margaret Cochenour
Memorial Hospital,
Red Lake, Ontario.

Registered Nurses' Association
of Ontario,
Toronto, Ontario.

Margaret Reid,
Toronto, Ontario.

Albert F. Richards,
Toronto, Ontario.

Robert N. Richards, M.D.,
Willowdale, Ontario.

The Riverdale Hospital,
Toronto, Ontario.

Marcella Robitaille,
Director, Clinical Records,
Mental Health Centre,
Penetanguishene, Ontario.

Royal Canadian Mounted Police,
Ottawa, Ontario.

Royal Ottawa Hospital,
Medical Records Department,
Ottawa, Ontario.

Lorne Elkin Rozovsky,
Halifax, Nova Scotia.

Borough of Scarborough,
Board of Health,
Scarborough, Ontario.

Service Employees' Union,
Windsor, Ontario.

Paul Shaver,
St. Thomas, Ontario.

Simcoe Hall Crippled
Children's Centre,
Oshawa, Ontario.

Arthur L. Smoke,
Willowdale, Ontario.

C. A. Squires,
Toronto, Ontario.

Statistics Canada,
Ottawa, Ontario.

Thistletown Regional Centre for
Children and Adolescents,
Rexdale, Ontario.

Don Tickle,
Collingwood, Ontario.

Marvin Tile, M.D.,
Toronto, Ontario.

Tillsonburg Town Police
Force,
Tillsonburg, Ontario.

City of Toronto,
Department of Public Health,
Toronto, Ontario.

Toronto East General and
Orthopaedic Hospital,
Toronto, Ontario.

University of Toronto,
Department of Psychiatry,
Ad Hoc Committee,
Toronto, Ontario.

University of Toronto,
Faculty of Medicine,
Division of Community Health,
Toronto, Ontario.

Herman Turkstra,
Hamilton, Ontario.

United Automobile Workers of
America,
Local 222,
Oshawa, Ontario.

United Steelworkers of
America,
Local 1005,
Hamilton, Ontario.

United Electrical,
Radio and Machine Workers of
America,
Local 504,
Hamilton, Ontario.

University Teaching Hospitals
Association,
Toronto, Ontario.

Varta Batteries Limited,
Willowdale, Ontario.

Elmyre M.G. Versteeg, M.D.,
Toronto, Ontario.

Susan Watt, D.S.W.,
Hamilton, Ontario.

Wawanesa Mutual Insurance
Company,
Toronto, Ontario.

University of Western Ontario,
Department of Computer
Science,
London, Ontario.

University of Western Ontario,
Faculty of Social Science,
Department of Psychology,
London, Ontario.

The Workmen's Compensation
Board,
Toronto, Ontario.

Borough of York,
Board of Health,
Toronto, Ontario.

York Central Hospital,
Richmond Hill, Ontario.

Young Men's Christian
Association of Metropolitan,
Toronto, Ontario.

Demetri Zavitzianos,
Don Mills, Ontario.

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